San Diego Union Tribune

Medi-Cal emergency

Scripps says it will drop out of the state plan May 1 if no agreement to increase reimbursements is reached

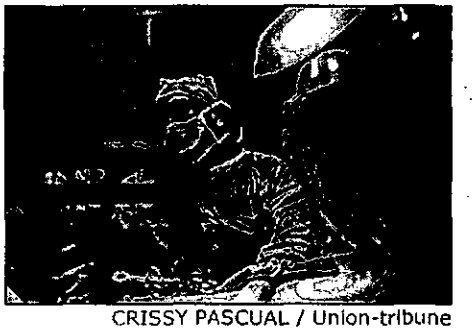
By Cheryl Clark
UNION-TRIBUNE STAFF WRITER

April 10, 2005

Scripps Health's five hospitals plan to stop admitting Medi-Cal patients for non-emergency care in three weeks because, their officials said, the state doesn't reimburse them nearly enough to cover treatment costs.

"This is a very serious decision and not one we take lightly. But we cannot continue taking care of the state's beneficiaries and pass costs on to insured patients," said Chris Van Gorder, chief executive officer for Scripps' 1,430-bed network.

He said the profit margin from commercial health plans, which Scripps uses to subsidize Medi-Cal care, has grown too thin.



CRISSY PASCUAL / Union-tribune
Dr. Jerrold Glassman, chief of the medical staffs for Scripps' Hillcrest and Chula Vista hospitals, performed a heart bypass

4/28/2005

March 24th, 2005

Dear Scripps Encinitas Community Advisory Board Member:

Registered Nurses at Scripps Encinitas care about our hospital, and our patients. We are committed to providing the highest quality of patient care to the community that we serve.

Over the last few years we have seen a deterioration in the level of care provided at our hospital, and an increased turnover of nurses. More than 1/3 of Scripps Encinitas RNs have less than 2 years at the hospital, and 3 out of 5 Nurses have less than 5 years. From March to November 2004, 34 RNs were hired and 28 RNs left. Last year, Scripps Encinitas spent over $3 MILLION on "TEMP" Nursing staff. (Information provided by Scripps in bargaining). Recent studies have revealed that there is an increase in negative patient outcomes associated with temporary nursing staff. This money would be better spent on recruitment and retention of experienced nurses to provide safe high quality care at our hospital.

We joined the California Nurses Association a little over one year ago, in an effort to work collectively to address these issues. After bargaining for almost one year, Scripps Administration gave us their final offer on February 18th, 2005. This offer was rejected overwhelmingly by Scripps Encinitas RNs in a 94% vote.

Encinitas RNs need a Staff Nurse Run Patient Care Committee driven by patient need instead of budgetary considerations, to make recommendations to improve patient care. We need an end to Subjective Merit Pay that has silenced Nurses from their duty as patient advocates and has resulted in unfair pay disparity. We need a competitive Salary Step Structure that rewards experienced RNs for their years of dedication and experience. We need a union membership provision that allows them the unity to be patient advocates.

Other San Diego Hospitals have met these standards. Palomar/Pomerado, UCSD, Alvarado, and Kaiser Hospitals have Staff Nurse Run Patient Care Committees and Union Membership Provisions. Palomar/Pomerado, UCSD, Kaiser, Alvarado and Sharp Hospitals have competitive salary steps. Subjective Merit Pay has been eliminated at Palomar/Pomerado, UCSD, Alvarado, Kaiser, Sharp, and Children's Hospital.

Over the last year, Encinitas Nurses have been documenting patient care concerns and have compiled the most egregious incidents into the attached document. The CNA Nurse Negotiating Team presented this report to Administration in an effort to resolve these issues in the context of bargaining. We were unsuccessful. We have included the "Patient Care Report" with this letter. We can no longer remain silent on these issues. We must stop the revolving door of RNs at Encinitas! We must improve the quality of patient care at our hospital!

We appeal to you, the Scripps Encinitas Community Advisory Board. We ask that you intervene on behalf of our patients, our hospital and our community.

The Scripps Encinitas CNA Nurse Facility Bargaining Council

Renee Menard, RN, ER; Betty Cavanaugh, RN, ER; Adele Borst, RN ER; Chris Lind, RN, ER; Katie Gibson, RN,

Scripps executives and California officials remain at odds after more than four months of negotiations.

operation, a procedure Scripps would no longer offer Medi-Cal patients if it drops out of the state health program.

Paul Cerles, supervising negotiator for the state commission that sets Medi-Cal reimbursement rates, said budget deficits have forced California to hang tough in the way it doles out more than $2.5 billion to 229 hospitals.

"We have been directed by the Legislature to not grant a rate increase," Cerles said.

If no agreement is reached by May 1, Scripps said, at least 3,400 patients would have to find new doctors connected to hospitals with Medi-Cal contracts. The time it takes to choose another physician, schedule an appointment and get retested for an illness could dangerously delay care, medical experts warned.

On a fiscal level, officials for several hospital systems fear a countywide crisis because their centers can't afford to lose more money by taking additional Medi-Cal patients.

The situation is exacerbated by the fact that the gap between reimbursement and the cost of care has risen dramatically in recent years, because patients are sicker, and because an increasing number of patients are underinsured or uninsured.

If Scripps follows through on its threat, at least one other hospital – Paradise Valley in National City – might bow out of its Medi-Cal contract as well.

Facilities in San Diego County have "never been able to climb to the reimbursement levels that put us on par with hospitals (elsewhere)," said Alan Soderblom, chief executive officer for Paradise Valley, owned by Adventist Health. "We're frustrated. It's not fair."

Paradise Valley lost a total of $14.7 million during the past five years, partly because of its Medi-Cal load. Sharp Chula Vista also saw a loss: $9 million in the past two years, according to CEO Chris Boyd.

Scripps executives said their Chula Vista hospital lost $14 million last year.

If Scripps goes through with its plan, the Chula Vista and Hillcrest operations would be most affected, with more than 2,400 patients having to go elsewhere for care.

Under state law, however, Scripps hospitals would still be required to take Medi-Cal patients through their emergency rooms. State reimbursement for emergency care would continue under different contracts.

The sticking point involves Medi-Cal contracts for non-emergency inpatient care. Van Gorder said Scripps realized it receives rates that are inexplicably lower than those of hospitals in other high-cost, urban areas in the state, especially Northern California. He said Scripps also gets less money than hospitals with similarly high levels of trauma and surgical expertise.

How much more Scripps needs can't be disclosed because state laws require Medi-Cal rates to be kept confidential for four years. But Scripps Vice President Marc Reynolds said "a major increase" is needed.

Statewide, hospitals are increasingly using threats to terminate contracts as a negotiating tactic, said

Cerles, who works for the California Medical Assistance Commission, the state agency in Sacramento that negotiates Medi-Cal payment rates.

Six hospitals have threatened to end their contracts this year, Cerles said. In 2004, Scripps pressed the commission for better contracts at its La Jolla and Encinitas hospitals, but a total of only 50 to 100 patients a month would have been affected.

Last April, Scripps extended its contracts one more year. Van Gorder declined to specify the terms, but he said the reimbursement issue was far from resolved.

This time, the commission acknowledges, Scripps appears to be taking a more drastic approach.

"We've never had a system in its entirety issue a termination notice for all of its hospitals," he said.

Cerles explained that contract rates are based on the amount of hospital competition in each county. Payments also reflect how badly the state needs a certain hospital's blend of services – for example, obstetric, intensive-care or surgical capabilities – to adequately treat Medi-Cal patients.

"We assess whether other hospitals in the area can absorb the load from Medi-Cal," he said.

That may be one reason San Diego County gets less money from the commission.

The region has five times the number of hospital beds needed for its population of Medi-Cal patients, according to the commission's 2004 report to the Legislature. That's greater than the state average of 4.3 times, and it exceeds the levels in San Bernardino, Riverside, Los Angeles, San Joaquin and Sacramento counties.

Whatever the reasons for Scripps' lower reimbursement rates, if the chain rejects Medi-Cal patients, the result will be sicker people who need even more expensive care, said cardiologist Jerrold Glassman,chief of the medical staffs for Scripps hospitals in Hillcrest and Chula Vista.

Glassman described what might happen in his specialty of heart disease:

Instead of performing angioplasties or stent procedures or recommending heart bypass surgeries for Medi-Cal patients, Glassman would tell them to visit a hospital that has a Medi-Cal contract.

"Hopefully, they would go and get worked up right away. But if they didn't, they would end up acutely in an emergency room with chest pains," which, he said, would be more costly for the state in the long run.

Other necessary procedures scheduled in advance include surgeries to remove cancerous tumors or to treat kidney, urological, gynecological and lung diseases. Among those patients forced to go elsewhere might be pregnant women scheduling their deliveries.

Finding specialists to provide outpatient care on a follow-up basis is already tough, Glassman and other doctors said. If the Scripps hospitals shun Medi-Cal contracts, the situation would become tougher because Scripps-affiliated doctors wouldn't want to serve Medi-Cal patients whom they couldn't hospitalize if necessary.

Mike Murphy, chief executive officer for Sharp Healthcare's five local hospitals, said he hopes Scripps

doesn't back out of Medi-Cal. He and Dan Gross, chief executive for Sharp Memorial in Kearny Mesa, predict a domino effect if it does.

"We're all having to look at whether we can continue to provide Medi-Cal services at these continued rates," Murphy said.

Other factors make the situation worse:

The federal government spends the least amount of money in California for Medicaid patients – called Medi-Cal in California – than it does in any other state. New York receives the most, $7,609 per enrollee, while California receives $2,068. That's $1,700 below the national average, according to the Kaiser Family Foundation.

Managed-care plans – including health maintenance organizations, or HMOs – became established earlier and more deeply in San Diego County than they did in many parts of California and the country. This allowed them to negotiate lower rates for care in the local area, rates that have purportedly influenced the reimbursement standards set by the county and state.

The uncompensated cost of providing mandatory care for thousands of undocumented immigrants appearing in emergency rooms is unknown. But local hospital officials said it clearly puts medical facilities in San Diego County at a greater financial disadvantage.

Scripps also said it receives less money than its peers from two state funds reserved for hospitals that take care of a disproportionate share of indigent patients.

For example, in the 2003 fiscal year, state records show that Scripps hospitals in Hillcrest and Chula Vista got a total of $9 million from these funds. That figure pales in comparison to the $55.3 million that UCSD Medical Center in Hillcrest garnered for its inpatient acute care.

During fiscal year 2000, another state fund for emergency and supplemental reimbursement paid $1.9 million to Scripps hospitals in Hillcrest and Chula Vista. By contrast, UCSD got $35 million.

Current reimbursement rates for Scripps and other hospital chains statewide are not available because of confidentiality rules.

The commission did supply the most recent reportable rates – from 2001. The list showed that four Scripps hospitals received an average of $862 per day per patient, lower than the average of $935 for all San Diego County hospitals and lower than the rates for most other major high-cost areas statewide.

The fifth hospital, Scripps Mercy in Hillcrest – a trauma center with a large segment of uninsured patients – received $1,000 per day per patient. But that rate was lower than the amount paid to many comparable hospitals with expensive trauma services.

When comparing hospitals with similar services, Medi-Cal rates seemed to be lower in San Diego County than in other urban areas. For example, in 2001 Paradise Valley in National City received $744 per patient, while a similar Adventist hospital in Los Angeles received $855 for each patient.

Steve Escoboza, spokesman for the Healthcare Association of San Diego and Imperial Counties, which represents hospitals, said he hoped Scripps' threat is merely a negotiating tactic. Yet he agreed with the region's hospital executives that "unless improved reimbursement is realized, they will have to consider

(discontinuing Medi-Cal) as an option."

Van Gorder and Reynolds still hope to reach an agreement with the state. They said a recent meeting with the commission yielded some progress.

However, the two men insist on holding firm to Scripps' request for higher payments.

"We can't continue to absorb losses that grow every year," said Van Gorder. To do so, he said, "is a formula for financial disaster."

▪Cheryl Clark: (619) 542-4573; **cheryl.clark@uniontrib.com**

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Chris D. Van Gorder, FACHE
President
Chief Executive Officer

Scripps

January 20, 2005

Allison Branscombe
Chief, Office of Regulations
Department of Health Services
MS 0015
PO Box 997413
Sacramento, CA 95899-7413

RE: Support of Regulation Control Number R-01-04E

Dear Ms. Branscombe:

Scripps Health is writing in support of the Department of Health Services' proposed revision of regulations governing nurse staffing in hospitals, regulation control number R-01-04E.

The revised regulations would: (1) maintain, until January 2008, the current limit of no more than six patients to one nurse on medical/surgical and mixed units; (2) provide hospital emergency departments with temporary staffing flexibility to respond to an unforeseeable influx of patients; and (3) clarify the requirement that the regulations be met "at all times" to allow nurses who temporarily step away for restroom breaks or phone calls to maintain their patient assignments as long as they physically remain on the unit.

We want to assure you that maintaining the 1:6 ratio is safe for patients. The flexibility the revised regulation allows will not jeopardize patient safety. The further evaluation of the effectiveness and viability of nurse-to-patient staffing ratios is important to accomplish before requiring more stringent staffing levels.

Additionally, the shortage of available nurses is well documented. As are most hospitals, Scripps is now having difficultly filling vacant nursing positions. California ranks 49th out of 50 in the number of nurses per capita. We continually have upwards of 200 open positions at Scripps despite aggressive recruiting efforts and substantial increases in compensation and benefits.

There are multiple reasons for the nurse shortage, including an aging nurse workforce, California's growing population and the fact that California is not educating enough nurses to meet our growing demands. California only graduates about 5,000 nursing students a year. It is estimated that California needs at least 10,000 nursing school graduates per year to address the nurse shortage. Scripps, along with other San Diego hospitals, is helping to fund increased educational capacity for nurses through our "Nurses Now" initiative.

But solving the nurse shortage will require much more and importantly – more time. It is appropriate that government, in its capacity as regulator, recognizes the existence of such limitations and give hospitals more time to work on nurse recruitment. Moreover, we hope that the state of California will be able to more substantially expand education programs for nurses. Until the number of nursing graduates improves, it seems likely that the nursing shortage will remain as a persistent and serious problem.

We have two disproportionate share facilities in the Scripps system that have placed us in a precarious financial condition. And we aren't alone. Eleven California hospitals have closed their doors in recent months. There are many reasons for this, including the large number of uninsured patients in California, inadequate government reimbursement for Medi-Cal and other low-income patient populations, unfunded seismic mandates, and numerous other factors that are driving up the costs of operating hospitals. All of this is further complicated by severe federal, state and local government budget problems, resulting in their inability to provide hospitals with financial help. In these difficult circumstances, we believe that the Schwarzenegger administration has correctly decided that the state should delay implementation of the 1:5 staffing mandate.

Scripps Health supports the Department of Health Services two-year study to determine the effects of the ratios on patients, workforce and hospitals. More research and analysis of the ratios is required, followed by reasoned and thoughtful changes. The ratios should protect patients, not cause them to lose access to hospital services. The unintended consequences resulting from the introduction of staffing ratios needs to be better understood. We believe that staffing standards can help in the effort to provide safe care. However, we also believe that there are many facets to improved patient care, including the introduction of improved technology which also demands the investment of hospital resources.

Sincerely,

Chris Van Gorder, FACHE
President and CEO

Cc: Tom McCaffery

Scripps Health Public Affairs
Office of the President
4275 Campus Point Court
San Diego, CA 92121-1513
Tel 858-678-6892
Fax 858-678-6131

Scripps

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NOV 2 9 2004

OFFICE OF REGULATIONS
DEPT. OF HEALTH SERVICES

November 12, 2004

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Dear Governor Schwarzenegger:

On behalf of Scripps Health and our five hospital facilities in San Diego County, we would like to thank you for the common-sense, reasonable modifications to California's nurse-to-patient staffing ratio regulations that were announced by your Administration on November 4.

We can assure you that Scripps is very aware the vital role that nurses play in delivering high quality patient care. Nurses are the backbone of every hospital. We can also assure you that regardless of any staffing regulation, Scripps will always maintain safe staffing levels. Our operating capacity is always determined by the number of qualified clinical staff we have available to maintain high levels of patient safety.

Our hospital administrators and managers, however, can speak from direct experience about the severe challenge facing hospitals due to our state's dire nurse shortage. Despite creative and aggressive recruitment efforts, our Scripps facilities currently have 277 vacant nursing positions. And Scripps is not alone. Most hospitals in the state have vacancy rates of between 15 percent and 20 percent as a result of the nurse shortage.

It's because of this severe shortage of nurses that the proposed changes in the nurse ratio regulations announced by the Department of Health Services are so important. These modifications will give our hospitals the flexibility we need to ensure that patients receive care in a timely manner.

Thank you, Governor Schwarzenegger, for putting the well-being of patients first.

Sincerely,

Michael D. Bardin
Senior Director Public and Government Affairs

cc: Pat Clarcy, Chief of Staff, FAX (916) 323-9991
Marybel Batjer, Cabinet Secretary, FAX (916) 323-0918
Jennifer Fitzgerald, Deputy Legislative Secretary, FAX (916) 327-1009
Kim Belshe', Secretary, Health & Human Services, FAX (916) 654-3343
Sandra Shewry, Director, Department of Health Services, FAX (916) 440-7404

Executive Compensation and Costs for Temp Nursing Soar at Scripps

While management refuses to meet community standards to recruit and retain skilled RN staff

Scripps squanders millions of dollars on executive compensation, plans for expansion (124 Million is the latest estimate per the North County Times 10/10/04), and temporary contracted nursing staff, while they refuse to provide the conditions to recruit and retain registered nurses at the hospital.

Skilled nursing care is why patients stay at a hospital. Yet, Scripps administration has refused to meet community standards by eliminating subjective merit pay, establishing competitive salary steps for experienced nurses, agreeing to union shop (to provide the collective power for RNs to be patient advocates), and agreeing to a staff-nurse run Patient Care Committee driven by patient needs, not budgetary constraints.

	10/00 - 9/01	10/01 - 9/02	10/02 - 9/03	1/04 - 9/04	% Increase
Cost of Temp Nursing Staff For Scripps Health		**$17,092,918**	**$20,094,266**	??	**18% Increase** in Temp Nursing staff costs
Cost of Temp Nurse at Scripps Encinitas		**????**	**???**	**$3.1 Million**	**LBMMC spent the same amount with 1500 RNs**
Chris Van Gorder President & CEO	**$573,180** Total Compensation	**$889,549** Total Compensation	**$1,042,270** Total Compensation	??	**82% increase (Sept. 2001 - Sept. 2003)**
Stanley Pappelbaum, MD, Retired President	**$995,552** (includes $$ for Exec. retirement and Exec. severance program)	**$842,612** (includes $$ for Exec. retirement and Exec. severance program)		??	Scripps paid retired President Pappelbaum close to $2 million in severance and retirement while they were also paying Van Gorder
Richard Rothberger, Treasurer & CFO	**$39,840** (partial year earnings)	**$412,956** Total Compensation	**$653,816** Total Compensation		**58% increase (Sept. 2002 - Sept. 2003)**
Arnold Eastman, MD Chief Medical Officer	**$427,547** Total Compensation	**$610,077** Total Compensation			**42% increase (Sept. 2001 - Sept. 2002)**

Information obtained from Scripps' 990 forms and from information provided by Scripps Encinitas administration to the CNA Nurse Negotiating Team

We must stand united on April 14! ***For more information call (619) 726-0366***

CALIFORNIA NURSES ASSOCIATION

CNA: A VOICE FOR NURSES ~ A VISION FOR HEALTHCARE

April 1, 2005

Dear Scripps Encinitas Doctors

Attached, you will find a series of documented problems that Scripps Encinitas RNs are currently experiencing. These problems keep us from being able to provide adequate patient care.

The problems include:

- Gross understaffing (not staffing to Ratios established under law, AB 394, or even to the Scripps Encinitas Staffing Guidelines.
- Staffing that does not take into account the acuity of the patients.
- Problems with temporary Registry and Traveler RNs.
- Lack of adequate numbers of RN staff in the skill mix and in overall numbers.

Nursing Management is aware of the problems we have documented here, but has been unwilling or unable to correct them. We presented these concerns to Scripps Administration during bargaining. There was no response at the table. We have reached the point where we have issued a 10 day notice of our intent to have a 1 day strike on April 14th, at the hospital. As you will see when you read the attached report, patient care is suffering as a result of Scripps high use of temporary contracted nursing staff, and the "revolving door" of RNs.

We must take action to ensure that our community receives safe high quality care. We ask that you join with us to improve care at this hospital. Tell Scripps Health to provide the competitive wages and working conditions necessary to recruit and retain our nursing staff. Tell Scripps to honor our demand for a Staff Nurse Run Patient Care Committee, driven by patient need instead of budgetary constraints. Tell Scripps to agree to a union membership provision that allows us to collectively advocate for our patients. And join us on the picket line on April 14th any time between 7 am and 11 pm.

If you are unable to be there to support us in person, we give you these suggestions of ways you can help:

1. Send food, or water to the picket line.
2. E mail Chris Van Gorder, CEO, and the Board of Trustees of Scripps Health on our behalf.
3. Demand accountability and safe patient care for our patients and the community.

Sincerely,

Renee Menard, RN, ER; Betty Cavanaugh, RN, ER; Adele Borst, RN ER; Chris Lind, RN, ER; Katie Gibson, RN, ER; Cheryl Jucksch, RN, ER; John Ong, RN, ER; Mike Pigott, RN, ICU; Steve Nyeholt, RN, ICU; Rocky Kosobud, RN, ICU; Betty Denny, RN, ICU; Sonia Guerreschi, RN, Women's Health; Rumiko Harkness, RN, Women's Health; Judy Mills, RN, Women's Health; Annalee Lehman, RN, Rehab; Linda Hager, RN, Rehab; Amy Kornasiewicz, RN, OR/PACU; Liz Gordon, RN, OR/PACU; Regina Limon, RN, Radiology/Cath Lab/Short stay; Andrea Little, RN, 2S; Melissa Clark, RN, 2S; Tonya Saliba, RN; 2S; Pauline Padgett, RN, 2S; Randy Calado, RN, 2S; Jeana Calado, RN,2S; Susan Henry, RN, 2 North; Susan Ciccone, RN, 2 North; Joan Loftin, RN, 2 North; Beverly Goddard, RN, 2 North; Diane Jackson, RN, 2 North; Processa Chan, RN, 2 North.

Patient Care Report
Scripps Encinitas Hospital

We have removed the exact dates and names to protect patient confidentiality. This information is available upon request.

April 2, 2005

To: Scripps Encinitas CNA represented RNs
From: Scripps Encinitas CNA Patient Care Committee

Thank you for documenting the patient care problems you have witnessed in the last months. The PPC is actively investigating the patient care problems that have been brought to our attention. We were only able to include a few of the reports we received in this packet, in large part because we were not able to fully research the rest of the reports we received in time for our presentation at negotiations. Many of the rest will be included in follow-up packets.

Please continue collecting the reports and submit them to your CNA unit reps.

We will do everything we can in order to get these patient care problems addressed and corrected, and to get the patient care protections we need in our contract.

This packet is for the information and internal use of Scripps Encinitas RNs represented by CNA.

Cath Lab/ICU
Mid February, 2005
Day Shift

Cath Lab RN needed in ICU prior to evening shift change to monitor and care for Balloon Pump patient since no ICU RN was available. Cath Lab RN had to care for the patient in the ICU and then transport the patient to a sister facility with cardiovascular services.

Patient care was impacted. There was no Cath Lab RN available for emergent procedures for 4 hours.

Cath Lab
Late January, 2005
Day Shift

Emergency 54 y/o patient with PTCA/STENT having an active heart attack was brought to Cath Lab from ER. Patient was not immediately transferred to the Cath Lab, despite insistence of ER Physician, due to a previously scheduled case in the Cath Lab and the fact that the cath lab was short one RN. Ultimately the patient was taken to the Cath Lab and procedure was started. The patient went into Ventricular tachycardia and had ventricular fibrillation and expired on the table. No code blue was called by the Lead RN. No documentation was done. There was no code blue note in the chart. This was

brought to the Radiology manager's attention the following day by another Cath lab member. The Lead RN filled out the code blue record 2 days after the patient expired. The coroner was not called. Hospital policy regarding reporting of sentinel events was not followed including notifying the coroner. ICU RN was called down by telephone to aid with patient. Lead RN sat by and watched while RNs and Doctor were trying to resuscitate the patient.

Sentinel Event. The patient expired. Lead RN acted inappropriately and failed to follow Cath Lab and Hospital Procedure for the safe delivery of care and the reporting of sentinel events.

Management is aware.

Cath Lab
January, 2004
Day Shift

Patient brought to Cath lab from floor for procedure. Patient placed on table and conscious sedation given by Lead RN without presence of physician, who stated he would be there shortly. The procedure RN arrived and checked the chart against the patient's arm band, and found the names didn't match. The wrong patient was on the table.

Patient care was impacted. Hospital Procedure was not followed to check the patient's arm band. Wrong patient was given conscious sedation. A heart cath was almost done on the wrong patient.

Management was aware. The Lead RN was suspended for 2 weeks.

ICU North
Fall, 2004

Ceiling fell in after a rain storm. Area not completely repaired for several months.

Patient care was impacted. Patients who were in beds next to the "hole" had to be moved to other beds. We could not use this room for several days.

Management was aware. The problem was eventually solved.

ICU & Emergency Department
Late November, 2004
Night Shift

On Call MD was unavailable and couldn't be reached for over 5 hours despite being the internist on call for the ICU and the ER. 42 calls were placed to his service and cell phone. 4 ICU RNs needed to talk with him about patient care issues.

Patient care was impacted. Care was delayed. An ICU patient in the ER who needed to be admitted was finally admitted by another doctor who did not know the patient.

Management was notified. They said there was nothing they could do.

ICU & Emergency Department
Early December, 2004
Day Shift

All ICU and hospital beds were full. A patient with Shortness of breath and renal failure requiring dialysis came to the ER. The House Supervisor asked the ICU charge nurse if the break RN in the ICU could go to short stay to sign out the patient after dialysis. The patient was to be dialyzed by an outside contracted agency. The ICU charge nurse informed the House Supervisor that the break RN was unavailable for a four hour dialysis treatment and could not accept the responsibility for only signing out the patient, if they weren't assessing the patient's condition during the procedure.

Patient care was impacted. The House Supervisor put the patient in the rehab unit during the dialysis procedure, adding to the rehab RNs assignment, and potentially impacting patient care.

ICU
Early December, 2004
Night Shift

Room 515 was cleaned by housekeeping at 1930 after a patient was discharged. The room was needed for an ER admission. Upon inspection, the Charge RN found that the floor was still sticky and there was trash on the floor. Dirty Suction containers had not been removed.

Patient care was impacted. The Patient admission from the ER was delayed for at least one hour since the room needed to be re mopped and containers emptied.

Not sure if Management was aware.

ICU & Emergency Department
Early December, 2004
Night Shift

There were no beds in the ICU and no beds in the hospital. A Patient came into the Emergency Department at 0300 with a subdural hematoma. The patient was unable to be admitted to the ICU, so was held for observation in the ED until 0730 when a bed was made available, but the patient had already died.

There were not enough RNs in the Emergency Department to provide appropriate care for the patient. The patient should have been staffed as a critical patient who needed constant neuro checks (at least a 1:2 ratio). The Emergency Department has inappropriately increased staffing with more LVNs each shift.

Management was aware.

ICU, Emergency Department, and Med Surg
December, 2004
Night Shift

The ER called with 2 ICU admissions at 2000. ICU was unable to take the patients because there were no beds available on the med surg units to take ICU transfers who had transfer orders to telemetry that had been written at 1000 am in the morning.

Patient care was impacted. ICU patients being held in the ER (one on a ventilator) were not cared for using ICU criteria for staffing (1:2). There was potential for a bad patient outcome.

Management was aware. Stated they had no solution.

ICU
Mid December, 2004
Night Shift

For two nights in a row, 3 units were open which were geographically far apart. There were a total of 23 patients during the shift. There was no relief/break nurse and no secretary. Charge RN had to relieve for all breaks, do all the paperwork for 4 admissions one night and three admissions the next, and be troubleshooter for all three units.

We also had a patient admitted who had Coded on the floor and was transferred to the ICU after being intubated. After being transferred to the ICU, central lines for hemo dynamic monitoring were started.

Patient care was impacted. There was potential for mistakes since the charge RN was stretched to thin.

Department Director was aware. Stated agreement that the situation was potentially unsafe.

ICU
Late December, 2004
Night Shift

Night Staff RN got report from Registry RN who stated Fentanyl and Dopamine drips were hanging at certain rates. After the Registry RN left, the staff RN assigned to the patient was making rounds and noticed that the Fentanyl drip was infusing at 3 X the ordered rate, and ***Dobutrex*** was hanging instead of Dopamine, also at the wrong rate.

Patient care was impacted: The patient was hypotensive and very difficult to arouse. Problems with Registry RNs are ongoing in the unit which is not able to recruit enough staff nurses to cover the 20 bed unit.

Management was notified immediately by the ICU Charge RN.

ICU
Late December, 2004
Night Shift

Registry RN who had only been to Scripps Encinitas once before, had an Insulin drip infusing at the wrong rate from what was ordered.

Patients blood sugar was only 19 (normal range is 60 - 100), and patient was obtunded (very lethargic and difficult to arouse). Charge RN intervened and Insulin was discontinued. Patient was given D50 W I amp IV and after 30 minutes, the patient's condition stabilized.

Management was notified.

ICU
Late December, 2004
Day Shift

Anemic and hypo volemic patient. Patient's 6 am H & H documented down from previous H & H. Doctor was aware and ordered repeat H & H at 10 am. Registry RN assigned to the patient was unable to retrieve and report H & H result to doctor in a timely manner. The doctor said he did not receive the H & H results until 1300. Registry RN said she was unable to access computer since she had no password.

Sentinel event -- The patient expired.

The responsible Doctor was aware.

ICU
Early January, 2005
Day Shift

Not enough staff to provide a break RN for day shift staffing. There were 20 patients and 11 RNs. The charge RN was able to provide a lunch break for only one RN. The rest of lunch breaks were covered at 4:1 ratios. When RNs had to accompany patients to X Ray or to MRI, the staffing was 4:1 as well. This is a violation of AB 394 – staffing ratio regulations which require that no ICU RN ever be required to care for more than 2 patients.

Patient Care was delayed. There was potential for bad patient outcomes.

Management was aware...

ICU
Ongoing January, 2005
Day Shift

Not enough regular RN staff. Therefore ICU North was completely staffed by Travelers or Registry on a regular basis. There were no staff RNs assigned to ICU north for most

of the month, and no secretary. The Charge RN had to cover two units (ICU North and South).

Patient care was impacted. There was a delay in care. Registry staff were unable to use the computer to check lab results or order stat order. They don't know the usual routine of the unit and couldn't find equipment.

Management is aware. Nothing has been done. We continue to use high amounts of temporary registry and traveler staff.

ICU – North
January, 2005
Night Shift

RN received report from night shift Registry RN who said that patient's finger stick blood sugar was over 120, and that she had given the patient subcutaneous insulin. During the report, the lab called and stated that the blood glucose drawn at the same time as the Registry said she had done the finger stick was 24. Staff RN checked the only machine used for doing finger sticks in the unit and could find no blood sugar result that matched what the registry RN had reported.

Patient care was impacted. The patient had to be given IV dextrose X 2.

Manager was notified, but nothing was done. The same registry RN came back to work the following night.

ICU
Mid January, 2005
Day Shift

Registry RN failed to follow MD orders to check serum magnesium and potassium after patient received a potassium replacement. In addition, the Registry RN did not chart that the patient had restraints.

Patient care was impacted. The patient had a low potassium and magnesium level. The patient had several runs of PVC's (premature ventricular contractions) all day and had Ventricular Tachycardia. Electrolytes were checked and replaced.

Management was aware. Registry RN was spoken to.

ICU
Late January, 2005
Night Shift

Medication orders were not transcribed to MAR or corrected by Registry RN. Medications were given but not charted on the MAR. The time meds were given conflict with information from the Pyxsis. The patient did not receive their medications in a timely manner.

Patient care was impacted. 2 doses of medication were missed. There could have been potentially unsafe patient outcomes.

Management was aware.

ICU
Late January, 2005
Night Shift

Registry RN did not chart on Medication Administration Record (MAR) but states she gave the medications. MD orders for stat lab tests not done on day shift by Registry RN. So Night shift staff RN had to note orders and saw that an order for 2 units of blood was missed.

Patient care was impacted. There was a 12 hour delay in giving blood, with dangerously low Hgb/Hct. There could have been a bad patient outcome.

ICU
Late January, 2005
Night Shift

Registry RN did not sign off 0900 medication, so there is no way to determine if the medication was given. A 0900 order for Thiamine was signed off, but was still loaded in the mini infusion, and was not given.

Patient care was impacted. The patient missed at least one medication.

Management was notified.

ICU
Late January, 2005
Day Shift

Day shift Registry RN had a duplicate Medication Administration Record. It was not corrected per the physician orders. 3 meds were deleted and were missed for 36 hours.

Patient care was impacted. There was a delay in medication administration with resulting patient agitation, and a small seizure. Night shift staff RN had to redo and correct the Medication Administration Record, adding to her workload.

Management was aware.

ICU
Early January
Night Shift

Emergent "Stat" order for Magnesium Sulfate written early am. Not given until 8 pm because Registry Day Nurse never saw the order. Finally noted by oncoming night shift staff RN. There was a delay in treatment for over 12 hours.

Patient Care was impacted. Potential risk of bad patient outcome.

ICU
Early January
Night Shift

Registry RN was giving report while insulin drip ran dry, along with the maintenance IV. New orders for meds were not transcribed on the MAR. No meds were ever charted for day shift.

Patient care was impacted. The patient's blood sugar level was high since4 he didn't receive the correct insulin dose. It took several hours to stabilize the blood sugar levels. Registry RN gave substandard care. Don't know if management was aware.

ICU
Middle January
Night Shift

Registry RN failed to follow MD orders to check Potassium and Magnesium levels after Potassium replacement given. Patient in restraints without documentation.

Patient care was impacted. Potassium and magnesium levels were low. Patient had PVCs and V Tach on and off all day.

Management was aware. Registry RN spoken to. Lab tests ordered.

ICU
Mid January
Night Shift

Registry RN was updating MAR and deleted and missed 3 medications for over 36 hours. Staff RN found error.

Patient care was impacted. Patient had one small seizure as a result of the missed meds. Night Shift Staff RN had to correct and redo 14 pages of MARs which took the RN away from patient care.

ICU
End of January
Night Shift

Medications: 0900 Protonix not signed off, so there is no way to know if it was given. A 0900 Thiamine was signed off but was still loaded in the mini-infusion and was not given. Registry RN assigned to this patient.

Patient care was impacted. Patient missed at least one dose of medication.

ICU
End of January
Night Shift

Registry RN missed Doctor's orders for "Stat" labs on day shift. The MAR was not correct per MD orders. Found by oncoming staff RN. Patient needed two units of blood and order was missed.

Patient care was impacted. There was a twelve hour delay in giving 2 units of blood. Staff RN had to spend valuable time correcting mistake of Registry RN.

ICU
Mid February
Night Shift

Patient admitted to ICU with Potassium of 1.9. Registry RN rudely tried to interrupt a Doctor who was dictating. He told her to wait until he had finished. She never returned to ask the doctor for Potassium protocol, nor did she notify the charge nurse. The potassium then went down to 1.8.

Patient care was impacted. The patient had life threatening potassium levels all night.

Management was aware. Registry RN was spoken to, and possibly made a DNR.

ICU
Early March
Night Shift

Registry RN started Propafol drip but IV was programmed wrong, and incorrect dose was infusing. Patient therefore did not receive sufficient medication to accomplish the purpose.

Patient care was impacted. Patient was agitated and moving around and fighting the ventilator while they could have been asleep if the dosage had been correctly given.

Management was aware.

ICU
Late February
Night Shift

Night shift staff RN went to deliver 2200 dose of antibiotic. Found previous dose undelivered and went to dispose of it. Night Shift RN then found the previous dose also undelivered. This means the patient had missed 24 hours of antibiotics by two registry RNs.

Patient Care was impacted. The patient had an increased white count and fevers post operatively. Management was aware, nothing was done.

Emergency Department
Late July, 2004
Day Shift

Not enough staff assigned to day shift. One RN was did Triage and was Charge Nurse in the Department. No breaks or lunch taken. RN complained of being very stressed out from trying to do 2 jobs. Violation of Staffing Regulations (AB 394), and potentially unsafe care.

Patient care was impacted. Patients had long waits before being seen.

Emergency Department
Late July, 2004
Day Shift

One RN assigned to an admitted ICU patient in the ED, on top of 3 other patients. Another RN assigned to an admitted ICU patient in the ED on top of 2 other patients. This was a violation of AB 394, safe staffing regulations, which states that staffing for ICU patients in the ED must be in addition to core staff and that ICU patients must be staffed at no more than 1:2 ratio of RN to patient.

Patient care was impacted. Care was delayed. "Non essential" care was not given. Management was aware.

Emergency Department
Ongoing
All shifts

LVNs are being given primary care assignments in the ED with independent patient assignments. LVNs are being assigned to admit patients for Paramedic runs. This is a violation of the LVN scope of Practice, Title 22, and AB 394, the safe staffing ratio law. It is outside the scope of LVN practice to perform a complete patient assessment. RNs working in the ED have the responsibility of doing the patient assessments, and are legally liable for the patient care given. By giving LVNs an independent patient care assignment, the hospital is not only jeopardizing safe care, but is also violating staffing ratio legislation for the RNs, whose legal liability and assignment includes their own patients and the LVNs.

Scripps Encinitas is violating the LVN scope of practice, and AB 394, staffing ratio regulations. Patient care is potentially seriously impacted and jeopardized.

Management is aware.

Emergency Department
Early August, 2004
Night Shift

Charge Nurse also assigned to Triage patients. Triage was very busy so charge was not in unit. Another RN who already had 4 patients assigned to her was told to take over charge responsibilities (which included dispatching radio calls, ambulance runs, bringing patients to their beds, and helping other staff). One of the patients assigned to this RN was an ICU patient who should have been staffed as a 1:1 patient. The RN had to have a Respiratory Therapist stay overtime to provide 1:1 coverage for her ICU patient who was having difficulty breathing (dyspnea), in violation of safe staffing regulations.
Patient care was impacted and there was potential for a sentinel event. Patients had long waits and needlessly suffered before being seen. Care was delayed.

Management was notified. Told to do the best we could.

Emergency Department
Early August, 2004
Day shift

Charge RN had to take care of 2 patients assigned to another RN, in addition to her other charge duties (which included dispatching radio calls, ambulance runs, bringing patients to their beds and helping other staff), when a patient became unstable and was classified as an ICU admit. This is a violation of AB 394, the Safe staffing ratio law, which requires additional staff for ICU, admits in the ED, outside of the core staffing assigned.

Patient care was impacted. Longer waits for patients. Care was delayed.

Manager was notified.

Emergency Department
Ongoing, 2004
Days and Nights

RNs not relieved for breaks and lunch. Either RN gets no break/lunch, or RNs are forced to cover each other resulting in unsafe assignments. AB 394 safe staffing law is violated routinely.

Patient Care was jeopardized. Waits were longer; care was delayed. RNs were exhausted, hungry, and more prone to make errors in stressful environment.

Supervision/Manager is aware.

Emergency Department
Mid August, 2004
Day Shift

The Unit was incorrectly, and unsafely, staffed with an Emergency Medical Technician (unlicensed staff), instead of a Registered Nurse, when the manager refused to authorize an RN come in to take the place of an LVN who was out. The Charge RN was doing Triage as well as being assigned patients for 4 hours. In addition, they were responsible for the EMT's patients. This was a violation of safe staffing regulations, and the hospitals' own staffing matrix. People didn't get breaks.

There was potential for bad outcomes. Patients had long waits to be seen and the nursing staff was extremely stressed.

Management was aware.

Emergency Department
Mid August, 2004
Night Shift

RN was assigned an ICU patient on a ventilator who was not doing well after a cardiac arrest in addition to two other patients. ICU patients in the Emergency Department must be staffed at no more that 1 RN for 2 patients and the staffing for ICU patients in the ED must be in addition to core ED staff, per safe staffing regulations (70217). The RN assessed that the ICU patient needed 1:1 care due to the severity of their condition.

Patient care was impacted. The ICU patient needed more attention. There could easily have been a bad patient outcome.

Management was aware.

Emergency Department
Early December, 2004
Day Shift

Carl Etter, Scripps Encinitas CEO announced that patients are not to be transferred, even when the hospital is full, except in an emergency. The result of this policy is that up to 8 beds in the ED have been tied up with already admitted patients waiting for a bed in the hospital. However, emergency patients keep coming to the ED, often resulting in patients with chest pain waiting for long periods in the waiting room.

Management is aware.

Emergency Department
Late December, 2004
All shifts

LVNs are expected to relieve RNs for breaks and lunches. Patients in the ED often need continuous assessments. It is outside the scope of LVN practice to assess a

patient. RNs are legally responsible for the patients assigned to LVNs. Assigning LVNs to relieve RNs for breaks and lunches is a violation of AB 394, and represents potentially unsafe care. LVNs do not have the scientific training or knowledge to provide safe independent care in the ED.

Management is aware.

Emergency Room
Late December, 2004
Day Shift

One RN called in sick and was not replaced. So, of the remaining RNs, one was assigned to Hallway #2, rooms 2, 3, 4, 5, 6, 7, 8, and rooms 1642 to 1655 (where there was a code blue patient from a medic run); another had an already admitted ICU (1/1) patient; and another RN was in triage. As a result, a patient in room 8 couldn't get her blood drawn on time, a patient in room 2 had delays in her IV antibiotics and in addition to this, RNs were responsible for 3 new grad LVNs and their patients. The RNs had to give the IV medications for the LVNs' patients and assess the patients. Nurse ratios were violated.

Patient care was impacted. The hospital has hired 4 LVNs recently, instead of RNs. These LVNs are straight out of nursing school and have no experience. Our facility is so small that strong RNs are needed to provide adequate care for our patients.

Management was aware.

Emergency Room
Night Shift
Mid January, 2005

We had 2 sick calls for the night shift that were filled by Registry. That left only 1 staff RN, 1 unlicensed EMT, and 1 LVN who knew the department. The Registry nurses had never worked in the Emergency Department before. They didn't know the computer system or where supplies were kept.

Patient care was impacted. Patients had to wait longer for care. The one staff RN was placed in a very stressful and potentially unsafe situation, having to cover for the staff LVN's patients as well as assist the Registry nurses.

Management was aware.

Emergency Room
Day Shift
Late January, 2005

A new RN in the department was approached by an LVN she had never met before, and asked if she would hang an IV antibiotic for the LVN's patient. The new RN was still being oriented and it was very busy in the ER. The RN hung the medication, but had to delay her own work since she had to check the Doctor's order before proceeding,

and then hang the LVN's patient's IV medications. The LVN didn't even know the RN. She could have been anybody. There are too many LVNs working in the ER. RNs are being forced to do "double duty", due to the limited scope of practice of an LVN.

Patient care could have been seriously impacted. There is more likelihood of medical errors with increased workloads.

Management is aware. They continue hiring more LVNs for the ER.

Emergency Room
Late March, 2005
Night Shift

Staff RN on day shift took over a patient with r/o ectopic pregnancy as diagnosis. The patient had arrived at 10:30 pm the night before. Only one set of vital signs were documented on the chart in 9 hours by Registry RN. Protocol for this type of patient should have been vital signs every hour.

Potential for bad patient outcome. Management was notified.

Emergency Room
Late March, 2005
Night Shift

Staff RN took report on day shift of patient who had hgb of 7. When IV was checked it was clotted off. There was no way of telling how long patient had not been getting IV fluids. The patient needed blood. Blood pressure was 93/68 when checked at 0700. At 0900 Staff RN called blood bank to check if units of blood were ready. Blood bank stated that they had spoken to Registry RN at 0600 and notified her that blood was ready.

Patient care was impacted. Patient was given blood 3 hours late. Potential for bad patient outcome.

Emergency Room
Night Shift
Late March, 2005

Day Shift Staff RN came on and found that Registry RN had missed respiratory treatments X 3

Med Surg/Telemetry
All shifts
2004 - 2005

Wall behind sink in staff lounge has mold, is wet, and has chipped paint. The wall is falling apart. This condition has existed for most of last year. Possible OSHA violations.

Problem has been reported two times to engineering.

Med Surg/Telemetry
Late February, 2004
Day Shift

RN was given 7 patients to care for (violating the safe staffing ratio law). One of the patients became critical during the shift. In addition, 2 of the patients were on isolation; there were 3 patients with PICC lines and one patient with a portacath and IV pain meds ever hour. There was no staffing by acuity.

Patient care was compromised. No personal care (hygiene needs, etc), and no psychosocial care was given. Call bells were answered late, and meds were delayed. There was potential for bad patient outcomes.

Management was aware of the problem.

Med Surg/Telemetry
Late February, 2004
Day shift

RN was given 6 patients on Telemetry unit, in violation of staffing ratios. 5 of the 6 patients were on telemetry monitors. Staffing was not done by acuity. This was potentially unsafe care. Patients did not receive the necessary amount of telemetry monitoring due to the patient load.

Management was aware

Med Surg/Telemetry
Late March, 2004
Night Shift

Most RNs, including Charge Nurse had 5 patients, one RN had 6 (5 Tele patients and one non telemetry patient). A patient complaining of chest pain, called for a nurse. The Tele Tech, who answered the call light, was told by one RN that the RN assigned to the patient was on break. The Tele Tech then called the charge nurse to check on the patient, but the charge nurse had 5 patients of her own and wouldn't go to see about the patient. The charge nurse told the Tele Tech to call the RN assigned back from break. When the tele tech reached the RN on break, the RN said that that patient wasn't assigned to her. Finally, another RN who had observed the exchanges intervened and went to take care of the patient. This RN decided not to take a lunch break that day due to the problems with staffing and the resulting unsafe care.

Management was aware. Manager stated that it is not the charge RN's responsibility to delegate lunch relief. She said that nurses can cover each other during breaks, even if it means having 10-12 patients. This is directly in violation of AB 394, the safe staffing ratio law which provides for ratios at all times.

Med Surg/Telemetry
April, 2004
Day Shift

RN was given assignment including 2 telemetry patients, an isolation patient, a patient on peritoneal dialysis, a diabetic with an insulin drip with frequent accu checks, a patient on a heparin drip, and a dementia patient on restraints. The staffing was by matrix/census, not acuity.

Potentially unsafe patient outcomes. Patients did not receive the teaching they needed to get. Call lights answered late.

Management was aware. Told to do the best we could.

Med Surg/Telemetry
Mid April, 2004
Day Shift

RN who had signed up for 1330 lunch was told that she couldn't be relieved by the Charge Nurse because Charge RN was already covering for the Tele Tech. She was told to find another RN to relieve her, which would have made the RN responsible for 12 patients. RN took no break.

Potentially unsafe patient outcomes.

Management aware.

Med Surg/Telemetry
Late May, 2004
Day Shift

RN went to take lunch break but was told by Charge Nurse that she couldn't cover patients since she was giving "Chemotherapy" and had other patients to care for. House Supervisor stated she was also unable to cover patients since she was in "MRI". Patient care was not impacted since RN didn't take a break.
Management was aware.

Med Surg/Telemetry
Early June, 2004
Day Shift

RN was assigned 6 telemetry patients at the start of the shift, in violation of staffing ratios and patient acuity. A relief RN was finally brought in at 1 pm and assumed care of one patient.

Patient care was compromised. Meds were given up to two hours late, and non essential care was not given.

Management was aware.

Med Surg/Telemetry
Early June, 2004
Night Shift

Each RN was assigned 6 patients. Many of these were Telemetry patients, violating the safe staffing ratios, and patient acuity.

Patient care was compromised. There was the potential for bad patient outcomes. Call lights were answered late, and non essential care was not given.

Management was aware.

Med Surg/Telemetry
September, 2004
Evening Shift

RNs without ACLS were assigned to Telemetry patients. One RN told the supervisor, but was advised to accept the assignment. Later on, this RN got an admission that was on Telemetry and a Natrecor bolus and drip. The RN wasn't familiar with the medication and had to have the charge nurse switch her assignment to another telemetry admission.
At least 4 RNs from Rehab floated to the telemetry unit on that shift. None of them had ACLS or advanced dysrhythmia recognition.

This practice continued for many weeks.

Patient care was compromised. There were potentially unsafe patient outcomes.

Management was aware of the problem.

Med Surg/Telemetry
Late September, 2004
Evening Shift

RN was assigned 6 patients, of which 3 were telemetry patients. A patient that was supposed to be discharged never left. This was a violation of staffing ratio laws and was potentially unsafe.

Management was aware of the problem.

Med Surg/Telemetry
Early December, 2004
Day Shift

Patient was decompensating and needed to be transferred to the ICU. No beds available in ICU and no physician available to give order for 24 hours. RN was responsible for this patient and 4 others. This patient required 1:1 or 1:2 RN care. Staffing was done by matrix, not acuity.

Finally, after Pulmonary MD saw patient, they were immediately transferred to ICU.

Patient care was adversely affected. Potential unsafe outcome.
Management was aware.

Med Surg/Telemetry
Late December, 2004
Night Shift

35 patients on unit. No break nurse. Short staffed so that Charge Nurse had to take 5 patients and all other RNs had 6 patients. RNs that took breaks had to give patients to another RN, resulting in 1/9 staffing for two RNs during breaks. Delays in answering call bells; meds given late; Potentially unsafe care.

Management aware. Said there was nothing they could do.

Med Surg/Telemetry
Mid December, 2004
Day Shift

Manager took lead RNs out to lunch in the middle of the shift. They were gone from 11:30 am – 2:00 pm. This left the break RN with Charge duties as well as her own. As a result, 3 RNs did not get a lunch break.

Potentially unsafe assignments. Working without breaks could have led to unsafe care.

Management was aware.

Med Surg/Telemetry
Ongoing
All Shifts

Break RN was cancelled. Charge RN is unable to cover all RNs for lunch; therefore RNs are often unable to take lunch breaks.

Potential for unsafe care with no rest periods or nutrition.

Management aware.

Med Surg/Telemetry
Ongoing
All Shifts

RNs are consistently told by Manager and Lead RNs that LVNs can cover RN lunch breaks, and assess 5 or 6 patients independently. This is a violation of the LVN scope of practice. LVNs cannot assess patients.

This policy has the potential for bad patient outcomes. If there are untoward outcomes, the RN's license is on the line.

Management is aware, but has not changed their policy.

Med Surg/Telemetry
Late December, 2004

Night Shift

Nursing Supervisor told RNs on unit that she was unable to get enough staff. The Charge Nurse was then given a full assignment with 6 patients in addition to her charge duties. There was no break nurse and safe staffing ratios were not adhered to.

Patient care was adversely affected. Call lights took longer to answer. There was no available resource nurse, and a patient fall occurred.

Management was aware of the problem. They said to do the best we can.

Med Surg/Telemetry
Early January, 2005
Night Shift

90% of the RNs on the unit were from the Registry. The following morning, the RN assigned made rounds and found a patient on a Heparin drip with no patent IV site. The Heparin was dripping on the floor at 15 cc/hr. There was a 1 foot X 1 foot puddle of Heparin on the floor.

Patient was having active MI at the time (confirmed by lab work – elevated CKMB and elevated Trop).

Management was notified. Incident documented and report filed.

Med Surg/Telemetry
Early January, 2005
Day shift

The House Supervisor asked a patient (who was waiting for ride home after being discharged by MD) to wait in the lobby, so the room could be cleaned for a new admit. The House Supervisor then escorted patient to lobby, and left the patient alone in the lobby to wait for their ride.

This resulted in potentially unsafe care and liability for the hospital and the RN assigned to the patient. Patient was sitting in the lobby by themselves while they were still listed in the computer as a patient, and were still being charged for the room.

Med Surg/Telemetry
Late March, 2004
Night Shift

RN was given a telemetry patient as an ICU transfer in addition to the 5 med surg patients she already was caring for. The RN had no advanced dysrhythmia recognition training, and the staffing was in violation of state mandated staffing ratios.

Potential for unsafe patient care and bad outcome.

Management was notified.

Med Surg/Telemetry
Mid August, 2004
Night Shift

The hospital staffing matrix calls for 7 RNs (1 charge and 6 floor RNs). There were only 6 RNs assigned, so Charge RN was assigned 2 patients on top of charge duties, and another RN was assigned 6 patients (all patients were on Telemetry, in violation of staffing ratio law). There was no one to relieve for breaks.

Patient care was compromised. Potential for unsafe patient outcome. Violation of mandated staffing ratios.

Management was aware. They stated that it is okay to give RN more than 5 patients if she is working with an LVN. This doesn't take into account the fact that LVNs cannot assess patients. The RN is ultimately responsible for the patients. No RN can be assigned to more patients than the legal ratio calls for.

Med Surg/Telemetry
Early December, 2004
Day Shift

The RN assigned to relieve for breaks and lunch was transferred to 2 South along with 3 medical patients because 2 North needed the beds for surgical patients. RNs on 2 North had to cover each other on breaks, resulting in nurses taking care of up to 10 patients at a time. This is a violation of staffing ratios which are required to be in place at all times.

Patient care was compromised. Potential for unsafe patient outcomes. Patients had to wait longer for call lights to be answered.

Management was aware. RNs were told to do the best we could.

Med Surg/Telemetry
Ongoing
All Shifts

When it rains, a trash can is put underneath a chronic drip in the medication room where the ceiling leaks.

Management is aware. Nothing has been done.

Med Surg/Telemetry
Late January, 2005
Day Shift

A patient had a myocardial infarction (heart attack). The patient was admitted to the telemetry floor without a telemetry monitor. The patient experienced an MI while not on a telemetry monitor. No one was aware since the patient wasn't being monitored. The patient was ultimately transferred to a monitored room the next morning.

Patient care was impacted. If the patient had been admitted appropriately to a monitored bed, intervention could have been quicker.

Not sure if management was aware.

Med/Surg-Telemetry
Mid January, 2005
Evening Shift

No Charge Nurse assigned. RNs got no lunches or breaks. There was no backup for emergent situations or admissions.

Potential for bad patient outcomes. Management was aware.

Med Surg/Telemetry
Late January, 2005
Night Shift

Only one CNA for 34 patients. The CNA was given the highest acuity patients and had 9 patients total.

Med Surg/Telemetry
Early March, 2005
Evening Shift

Staffing exceeded mandated staffing ratios for 6 RNs. In addition there was no free charge. The charge RN was assigned 4 patients. The acuity of the patients was high, and the assignments violated Scripps Acuity tool. In addition, a RN with 6 patients had to orient a new hire RN. Management was aware, but did not ask anyone from day shift to stay over from the day shift to help out.

Patient care was impacted. Potential for bad patient outcomes. Scripps violated the law and their own staffing matrix.

Med Surg/Telemetry

Mid March
Day Shift

2 RNs with 6 patients and each with an LVN to assist them. The patients had the highest acuity on the floor. This was a violation of AB 394 which mandates that no RN shall be assigned more than 5 patients on med surg/telemetry.

Potential for unsafe care and violation of the law.

Med Surg/Telemetry
Late March, 2005
Day Shift

Started shift with 7 RNs who each had 5 patients, with high acuities. One of the RNs who was chemo certified, was pulled to rehab to give two chemo treatments. There was no break nurse. Charge RN was unable to relieve for breaks and lunch since she was covering for Chemo RN when she had to leave the floor. Even though we were short staffed, we were forced to accept additional admissions.

Management was aware. At 1300 an LVN was finally sent to floor to help out. Violation of AB 394 and hospital's own staffing matrix. Potential for unsafe care.

Med Surg/Telemetry
Late March, 2005
Day Shift

LVN called with report from the ED to RN on 2 South regarding a patient with active chest pain. LVN stated that patient had no chest pain, and was sent to floor. Patient arrived on floor with acute chest pain 7/10. Charge RN informed. LVN working out of scope of practice. Patient should have stayed in ER and been reassessed by RN and MD. The report should have been made by a RN.

Potential for unnecessary MI. Violation of Title 22.

Women's Health Pavilion
Ongoing
All Shifts

No RN is ever assigned to the nursery. Babies are kept at the nurse's station routinely when the mother takes a shower, wants to leave the unit, or is too tired to care for the baby at night. This is a direct violation of AB 394, staffing regulations, and title 22. When the staff RNs are in patient rooms, going to a delivery, or answering lights, the baby is watched by the unit secretary.

This is a potentially very unsafe practice.

Management is aware.

Women's Health Pavilion

Ongoing
All Shifts

New Born babies who are undergoing photo therapy (bili lights) for jaundice are not placed in the nursery where their condition can be monitored. We have no RN assigned to the nursery, so the babies are kept in the mother's room. The mother is told to make sure the babies' eyes are covered at all times. They are advised to let the RN know if the mask is off. This is a potentially unsafe practice. The mother may be taking a nap, or reading, etc. and not notice that the mask has slipped off.

Management is aware of the practice. There is no RN ever assigned to the nursery.

Women's Health Pavilion
November, 2004
Day Shift

Occasionally more than one new RN is orienting at the same time in our unit. Experienced staff RNs are then assigned to precept all of the orientees at one time, on top of having their own assignment. This is potentially unsafe practice and is a violation of safe staffing practices, title 22, and the hospital's own policies on RNs orientees not being given an independent assignment until they complete orientation.

Management was aware.

Women's Health Pavilion
November, 2004
Day Shift

A broken filing cabinet was reported to the manager, but nothing was done. The cabinet then fell on the unit secretary and she had to go to the ER for treatment. She was off work for several days.

The cabinet has still not been bolted down properly.

Women's Health Pavilion
December, 2004
Day Shift

A Registry RN left early. The staff RN who took over noted that no charting had been done on the patients assigned to the Registry RN from 0800 – 1600. We don't know if the patients were even seen during the day. This has happened before with Registry staff on the unit.

There could have been a bad patient outcome. There were no notes on the patient's conditions. No assessments were done for the day shift. There is a legal liability for the hospital.

Management was aware. Not sure what was done.

Women's Health Pavilion
Early February, 2005
Day shift

One RN was assigned 8 couplets, which is a violation of AB 394 and the hospital's staffing matrix. Another RN was given 3 labor patients which is also a violation of AB 394 and the hospital' staffing matrix. New admissions kept arriving even after all RNs had full loads. Charge RN was forced to take active labor patients on top of the 5 patients she was already assigned to. Finally a Registry RN came in and took over one of the active labor patients. Another RN completed the recovery of her patient and then took the 2nd active labor patient. The Charge RN delivered the 3rd active labor patient.

Patient care was impacted. One mother who had a baby in the NICU did not get emotional support or information about the baby. Meds were delayed. Potential for bad patient outcome.

Women's Health Pavilion
Early February, 2005
Day Shift

Short staffed. Told that no extra help was available. 2 RNs assigned to 2 active labor patients. 1 RN had an early labor patient and had 5 couplets on top of this. She also had to start 3 babies on phototherapy which was done in the patient's rooms. 1 RN stayed over from night shift until help arrived. This RN had 5 couplets (10 patients) to care for. 3 of these patients were later discharged, causing an increase in workload. The charge RN had 6 couplets and 4 discharges.

Patient care was impacted. One baby had a positive GBS protocol missed. Blood work had to be ordered later on and discharge was delayed. RN assignments changed every 2 to 3 hours causing loss of continuity of care and general confusion on the ward. Phototherapy for 2 babies was done in one room, since there was no room.

Acute Rehab
All Shifts
December 14th 2004

The Manager (Diane) put out a memo that stated: 1) Staffing ratios on the unit were being changed due to the unit being over budget. This is a violation of AB 394, staffing ratios, and title 22, which not only lay out staffing ratios, but state clearly that staffing must be based on acuity of patients, and not be budget driven; 2) that the use of sitters for agitated, confused patients needed to be decreased.

The memo went on to suggest alternatives to using a sitter for an agitated patient. **The suggestions included having the family stay with the patient, asking the other patient in the room to watch the patient, and putting the patient in a low bed.**

This approach to care is very unsafe. There is great potential for bad patient outcomes.

Acute Rehab

Late September, 2004
Evening Shift

At the start of the shift there were 13 patients. One RN was assigned 6 patients and the other was assigned 7 patients. One of the patients was supposed to go home, but a discharge time had not been determined. The Department Manager decided not to count the patient going home and to staff for 12 patients. The patient to be discharged did not leave until 6:15 pm, when one RN was at dinner. This left the other RN covering 12 patients. When 1 patient got a fever and hives the ward clerk had to help the RNs out with patient care because more hands were needed. This is a violation of AB 394 and the hospital's own staffing guidelines.

Patient care was impacted. One of the RNs had 3 isolation patients plus 3 primary patients. The other RN had a new admission, the patient waiting for discharge, and 4 other primary patients. 1 CNA was assigned 8 patients.
THREE incident reports were completed on this shift. RNs got no breaks and had to stay overtime to complete work.

Management was aware, but offered no help.

Acute Rehab
Late September and Ongoing
Evening Shift

There were 3 RNs assigned to 19 patients. When RNs spoke to the manager to request more staff to comply with the acuity of the patients and mandated staffing ratios (AB 394), they were told that there is "no such California law or hospital policy for Acute Rehab".. This is a direct violation of AB 394.

Patient care was impacted. RN was admitting a new patient in addition to her 6 assigned patients, so orders for Coumadin, Norco and Zofran were not carried out in a timely way since the patient's name was removed from the pyxsis (due to a pending transfer) before the RN could give the medicine. Patient had needless pain and suffering and had to wait until she was transferred to get the medication.

This is an ongoing problem. Management is aware. The manager continues to assign 7 patients to one RN.

Acute Rehab
December, 2004
Evening Shift

Started shift with 6 patients for each of 3 RNs. But 3 new patients were admitted, giving each RN 7 patients. The Nursing Supervisor had replaced a RN position on the evening shift matrix with a CNA. In addition, LVNs are given independent assignments. RNs are legally responsible for the LVN's patients. So the RNs really have 9 patients each. There is no staff available for admissions. These are violations of Title 22 and AB 394.

The 3 admissions took all the RN's time at the beginning of the shift. Other assigned patients were not assessed until late in the shift. Getting 3 new admissions at one time with not enough RNs assigned, led to confusion with the orders, and created an environment that was conducive to making errors.

Management is aware. Management and Physicians want all patients to be admitted before 5 pm. However, the new admits are not counted in the staffing matrix, even though it is generally known they are coming. There is no rapid deployment system of staff (mandated by Title 22 and AB 394).

Acute Rehab
December, 2004
Evening Shift

Staffing was 2 RNs and 3 LVNs for 24 Acute Rehab patients. The RNs were each responsible for assessing 12 patients, in violation of AB 394, staffing ratio legislation, which states no RN shall be assigned more than 6 patients.

1 patient assigned to an LVN developed shortness of breath over several hours and eventually had to be transferred to the ICU with acute respiratory distress, and elevated Blood Pressure.

Patient care was impacted by the staffing. If more RNs had been scheduled, the patient would have been assessed quicker and interventions would have started sooner. The serious change in the patient's condition may have been averted with earlier intervention.

Management was aware.

Acute Rehab
December, 2004
Night Shift

There were 24 patients. Initial staffing was 2 RNs and 2 LVNs. It was noted on the staffing sheet that the Registry LVN had to leave at 0530 to go to another job. After 0530 the remaining licensed nurses had 8 patients each for the rest of the shift. When 1 RN took a break, the other RN was responsible for all 24 patients.

Patient care was impacted. A patient with a history of COPD (assigned to the Registry LVN) had chest pain. An RN went to check on the patient and noticed that even though the patient had nasal O2 prongs in his nose, the O2 regulator on the wall wasn't even turned on. This patient was supposed to have Oxygen continuously.

Management was aware.

Recovery Room
Day Shift
Ongoing for several years

Incompetent RN didn't give ordered pain meds to patients who were requesting them. Transferred patients to floor instead of following department policy of notifying physician of complaints of pain. This RN didn't have the needed competencies for the department. Lead RN was notified of the issues by PACU and OR staff for months.

Patient care was impacted. Patients suffered needlessly, and meds were delayed.

Management was aware. RN was terminated after approximately 2 years of other staff RN and patient complaints.

Recovery Room
Night Shift (on call shift)
Ongoing

RNs on call who are called back to work, are by themselves in the PACU. The OR RNs leave the hospital following the surgery, leaving the PACU RN alone. Staffing should be 1/1 for at least the first ½ hour following surgery under general anesthetic. This staffing is often not followed. RNs have cared for 2 patients by themselves when they come in from call. There is no one to relieve them for breaks, lunch, and to go to the bathroom. If there is an emergency, there is no other RN available to assist.

Patient care is potentially impacted. There could be bad patient outcomes.

Management is aware.

Recovery Room
Day Shift
October 2004

1 RN didn't come in to work, leaving the other staff RN by herself in the PACU. The staff RN was then responsible for 4 patients, by herself. There is no emergency deployment system to deal with changes in census or to replace RNs who call in sick. This is a violation of Title 22 and AB 394, staffing ratios.

Management was aware. Manager told RN there was nothing she could do and to do the best they could.

Recovery Room
Day Shift
2004

New RN brought to unit without experience in the PACU. Lead RN ended orientation before the new RN had competency for the unit. The new RN was then given an assignment of a patient with an arterial line and needed a PCA pump set up. The new RN was unfamiliar with the appropriate care and nursing practices required for this patient. As a result, an overdose of morphine was almost given. Other staff RNs, with their own assignment had to intervene to avoid an untoward patient outcome.

There was potential for a serious patient outcome.

Management was notified. RN has since been given more training.

Recovery Room
Day Shift
January, 2005

Lead RN hired 1 new inexperienced nurse for PACU. Lead RN assigned her to orient with a staff RN who had no preceptor class. The inexperienced new RN worked for almost 2 hours by herself, with no other RN staff in the unit, before orientation was

completed. Patient care could have been impacted. This was a violation of Hospital standards and policies as well as Title 22.

Management was aware.

Scripps

III. PROJECT INFORMATION

TAB 4

A. Estimated sources of funds: Provide a breakdown of the following applicable sources of funds. Discuss whether equity or other funds will be targeted for any particular use.

Bond funds	$290,025,000
Equity funds	0
Other funds (itemize)... DSRF	$7,238,000
Total sources of funds:	$297,263,000

B. Estimated uses of funds: Briefly describe the general purpose of this financing (e.g. refunding to lower interest costs, construction to satisfy demand for certain services, etc.) and identify the following applicable uses of funds.

Real Estate (Land) purchase.....0
Describe the property (location and size) and its intended use.
Provide a copy of the purchase agreement and a current appraisal.

Construction or renovation.....$71,000,000[1]
Provide schedule for construction. Describe the project(s) and discuss any change in the bed complement resulting form your project. Answer the following project readiness questions;

1. Have all required permits and approvals been obtained – if no, status?

Compendium of projects, which the majority are for construction and equipment, are in early stage of planning. **See Attached.**

2. Has a construction/renovation contract been signed – if no, status?
   If yes, what is the guaranteed maximum price?

Compendium of projects, which the majority are for construction and equipment, are in early stage of planning. **See Attached.**

Equipment Purchase.....$21,464,566[1]

Provide a general description of the items to be purchased.

Note(1) Compendium of projects, which the majority are for construction and equipment, are in early stage of planning. Therefore, the cost of projects is subject to change. **See Attached.**

Health facility acquisition or merger.....0

1.) Provide audited statements for the last three years and year-to-date interim financial statements of the facility to be acquired or merged. 2.) Describe the facility to be acquired or merged, including the location, bed complement and assets. 3.) Describe the purpose of the acquisition or merger and answer the following questions:

1. Is the acquisition/merger contract complete – if no, status?
2. Has an appraisal been completed – if not, explain.

Reimbursement.....$10,506,934[2]

Provide a general description of the items to be reimbursed.
(Federal tax law imposes certain requirements for reimbursement. Check with your bond counsel before expending any funds to be reimbursed.) **See Attached.**

Note(2) Scripps management and bond counsel will be reviewing the reimbursement list to comply with federal tax law. The final review will occur prior to closing date of the bond issue. Therefore, the above reimbursement amount is subject to change.

Working capital.....0

There are limiting conditions for financing working capital.
Please confer with your proposed bond counsel to determine any limitations.

Refunding.....$191,721,000

For proposed new debt provide: **See Attached**

1. Type of refunding (advance, current or cross-over) and detail of anticipated costs (i.e. breakout of escrow costs and any prepayment costs of refunding old debt); and
2. A cost savings analysis. Show:
   - debt service savings by year;
   - total savings;
   - present value (PV) of total savings;
   - the ratio of PV savings to the par amount of the new debt.
3. If no cost savings, state the reason for the refinancing.

Scripps has been evaluating all of its existing debt for restructuring opportunities. The plan of finance has been developed on a global basis,

where all of the existing debt is analyzed to determine the specific series of debt to be refunded. The Series 2005 refunding and new money bonds are structured to combine with the existing indebtedness to stretch out the length of the debt and provide the lowest overall maximum annual debt service. As seen in "Exhibit A of Tab 4", there are savings on a global basis, but savings have not been analyzed on a series by series basis.

For debt to be refunded provide: **See Attached**

1. Name of the issuer;
2. Name, year and series of the bonds;
3. Amount of bond issue/loan;
4. Amount currently outstanding;
5. Interest rate (index if variable rate);
6. Maturity date;
7. Brief description of the purpose of the original debt; and
8. State whether original project complete.

Estimated other uses (total):.....$2,570,500

Provide the following applicable costs: **See Attached**

1. Debt service reserve
2. Other reserves (describe)
3. Capitalized interest
4. Working Capital
5. Insurance/Bank fee
6. Counsel fees
7. Financial advisor
8. UW Discount
9. Other (List)

Total uses of funds (must equal "Total sources of funds").....$297,263,000

C. Additional Project Information: Provide the following information about the project:

See Attached.

1. List the city, county, and precise street address of all facilities receiving financing.
2. For renovation or construction projects, list the name of the construction company or developer (if one is already chosen) completing the work.
3. List the name of any other lender or credit enhancer.
4. For property acquisition, list the name of the seller of the property.
5. For refinancing projects, list the name of the financial institution(s) holding the loans to be refinanced.

The 2005 Plan of Finance will total up to $295 million of floating rate bonds insured by Ambac, and accordingly rated triple-A. The 2005 Bonds will be in the form of either Auction Rate Securities ("ARS") or a combination of ARS and Variable Rate Demand Bonds ("VRDBs"). Both will be repriced every seven days by Citigroup Global Markets Inc. as broker-dealer/remarketing agent. Closing for the Bond sale could occur as early as mid May. A financing timetable is included in Tab Seven of the Application.

Approximately $230 million of the $295 million 2005 Bonds will be transformed to a net fixed rate exposure for Scripps Health through the use of a floating to fixed interest rate swap. The result will be that Scripps Health will achieve its targeted floating to fixed rate debt mix of 50/50. The swap will be priced as a percentage of LIBOR and is expected to produce an extremely competitive fixed cost of capital. It may be executed as early as mid April if interest rates are favorable. Citigroup will be the counterparty.

The purposes of the 2005 Bonds are as follows:

1) To refund the Authority's Series 1985B, 1991A, 1992A, 1993A and 1998C Bonds in their entirety, as well as a portion of the 2001A Series. The refundings are expected to lower Scripps Health's per annum debt service to accommodate the new yearly payment obligations associated with item 2) below.

2) To fund approximately $100 million of new money projects in accordance with Scripps Health's strategy capital plan. The list of financeable projects includes:

• Parking structure for Encinitas	$11.6 million
• La Jolla parking structure	$18.0 million
• La Jolla imaging pavilion	$11.0 million
• Parking structure for Mercy	$19.0 million
• Cath labs (multiple sites)	$22.6 million
• PACs for imaging (multiple sites)	$6.1 million
• Short lived equipment	$42 million

Scripps

V. BOND ISSUE STRUCTURE / FINANCING TEAM:

TAB 6 Describe the proposed structure of the bond issue as follows:

A. Interest rate: variable.
B. Term: initial and final maturity.
C. Type of credit enhancement, if applicable.
D. Type of offering: public, private placement or limited public offering.
E. Financing team (include names, title, phone and fax):
   - Senior underwriter;
   - Suggested co-managing underwriter(s);
   - Bond counsel;
   - Underwriter's counsel;
   - Disclosure counsel, and
   - Arbitrage rebate calculation firm.
F. Rating agency(s) for financing and expected credit rating(s) for this financing.
G. Identify the most recent credit rating of the Applicant and the Guarantor, if applicable, and the name of the rating agency(s).
H. Estimated costs of issuance.
I. Estimated underwriter's spread, including a breakdown of estimated expenses.

The 2005 Plan of Finance will total up to $295 million of floating rate bonds insured by Ambac, and accordingly rated triple-A. The 2005 Bonds will be in the form of either Auction Rate Securities ("ARS") or a combination of ARS and Variable Rate Demand Bonds ("VRDBs"). Both will be repriced every seven days by Citigroup Global Markets Inc. as broker-dealer/remarketing agent. Closing for the Bond sale could occur as early as mid May. A financing timetable is included in Tab Seven of the Application.

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• PACs for imaging (multiple sites)	$6.1 million
• Short lived equipment	$42 million

Resolutions of the Board of Trustees
Of
Scripps Health
(2005 Plan of Finance)

WHEREAS, management of Scripps Health (the "Corporation") has presented to this Board of Trustees for its consideration and approval a Plan of Finance, consisting of the following elements:

- Either the California Statewide Community Development Authority or the California Health Facilities Financing Authority (each, the "Issuer") will issue revenue bonds in one or more series (the "Series 2005 Bonds") pursuant to a bond trust indenture ("Bond Indenture") between the Issuer and a bond trustee to be selected by the Corporation, acting through its Plan of Finance Committee (described below). The aggregate principal amount of the Series 2005 Bonds will not exceed $290 million.

- The Corporation will borrow the proceeds of the Series 2005 Bonds pursuant to a loan agreement ("Loan Agreement") between the Issuer and the Corporation, and will use the proceeds of the loan to refinance existing debt, reimburse the Corporation for certain capital expenditures that have been completed (consistent with the requirements of federal tax laws) and finance additional approved capital expenditures.

- The Corporation will also borrow a portion of the proceeds of another series of bonds (the "SWEEP Bonds") to be issued by the Issuer pursuant to a loan agreement (the "SWEEP Loan Agreement") between the Issuer and the Corporation, the proceeds of which will be used to finance approved capital expenditures. The principal amount of the amount to be borrowed pursuant to the SWEEP Loan Agreement will not exceed $100 million to the extent such capacity, in combination with proceeds from the Series 2005 Bonds, is necessary to fund up to $150 million in capital expenditures.

- <u>The total amount borrowed for new money under both the Series 2005 Bonds and the SWEEP Loan Agreement shall not exceed $150 million</u>.

- The obligations of the Corporation under the SWEEP Loan Agreement will be secured by a letter of credit ("SWEEP Letter of Credit") to be issued by Citibank (the "Bank") pursuant to a reimbursement or credit agreement (the "SWEEP Bank Agreement") between the Bank and the Corporation.

- Assuming terms (including premium and covenants) that are acceptable to the Plan of Finance Committee, the Series 2005 Bonds will be insured by Ambac or another bond insurance provider ("Bond Insurer") pursuant to a bond insurance policy ("Bond Insurance Policy") of the Bond Insurer.

- The Series 2005 Bonds will be issued in one or more series, in a mix of Series 2005 Bonds bearing interest at fixed rates and Series 2005 Bonds bearing interest at variable rates, either as variable rate tender bonds or as auction rate bonds, the exact mix to be approved by the Plan of Finance Committee.

- The Corporation will hedge its interest rate exposure on the Series 2005 Bonds bearing interest at variable rates by entering into a interest rate swap agreement or agreements or other hedge agreement or agreements (the "Interest Rate Swap"), in a notional amount not exceeding the aggregate principal amount of the Series 2005 Bonds bearing interest at variable rates. The obligations of the Corporation under the Interest Rate Swap to make periodic payments and, under circumstances to be described in the Interest Rate Swap or to make termination payments, will be insured by the Bond Insurer.

- Pursuant to a supplement to the Master Indenture (the "Master Indenture Supplement"), the Corporation will issue several Obligations under the Master Indenture to the Issuer (or to the bond trustee of the Series 2005 Bonds) to secure its obligations under the Loan Agreement; to the counterparty or counterparties under the Interest Rate Swap; if required by the Bond Insurer, to the Bond Insurer to secure the obligations of the Corporation to the Bond Insurer; if required by the Issuer, to the Issuer (or to the bond trustee of the SWEEP Bonds) to secure its obligations under the SWEEP Loan Agreement; and to the Bank, to secure the Corporation's obligations under the SWEEP Bank Agreement.

- Pursuant to the Supplement to the Master Indenture, the Corporation will pledge its receivables and certain other revenue to the Master Trustee to secure the Obligations described herein as well as all other Obligations outstanding from time to time under the Master Indenture.

- The Series 2005 Bonds will be sold to Citigroup Capital Markets ("Citigroup"), the Corporation's underwriter and investment banker, pursuant to one or more bond purchase contracts ("Bond Purchase Contracts") between the Issuer and Citigroup, and pursuant to one or more letter or letters of representation to be delivered by the Corporation under the Bond Purchase Contracts.

- The Series 2005 Bonds will be offered to investors pursuant to one or more preliminary official statements and official statements (collectively, the "Official Statements") of the Issuer and the Corporation.

WHEREAS, the Finance Committee of the Board of Trustees has considered and approved, and recommended that this Board approve an Interest Rate Swap Policy, which is being approved by this Board on this date.

WHEREAS, it is in the best interests of the Corporation to proceed with and implement the Plan of Finance.

WHEREAS, to accomplish the Plan of Finance and the issuance of the Series 2005 Bonds, it will be necessary for the Corporation to execute, enter into or approve all documents necessary to complete such transactions, including agreements, letters of representation, certificates, promissory notes and other documents, the forms of which shall be acceptable to the President/Chief Executive Officer or the Executive Vice President/Chief Financial Officer of the Corporation (the "Authorized Officers").

WHEREAS, the Board of Trustees has determined that the implementation of the Plan of Finance as described in these Resolutions, and the execution, delivery or approval of all documents and the taking of such actions as may be necessary to accomplish the transactions described herein, are all advisable and in the best interests of the Corporation and are consistent with the purposes of the Corporation.

NOW, THEREFORE, BE IT AND IT IS HEREBY RESOLVED BY THE BOARD OF TRUSTEES OF SCRIPPS HEALTH:

1. The implementation of the Plan of Finance as described herein, including, but not limited to, the incurrence of indebtedness in an amount not to exceed $390 million (representing the borrowing of the proceeds of the Series 2005 Bonds in an amount not to exceed $290 million and the borrowing under the SWEEP Loan Agreement in an amount not to exceed $100 million) and the use of the proceeds of that indebtedness to refinance existing indebtedness, reimburse the Corporation for capital expenditures already made and finance additional approved capital expenditures, is approved.

2. The Corporation is authorized to enter into one or more Interest Rate Swaps for the purposes described herein, provided that the Interest Rate Swaps are consistent with the Interest Rate Swap Policy and are reviewed and approved in the manner contemplated and directed by the Interest Rate Swap Policy. If required by the counterparty or counterparties, or by the Bond Insurer, and if approved by the Plan of Finance Committee, the Corporation is further authorized to pledge to the counterparty or to the Bond Insurer under the Interest Rate Swap agreement or agreements cash collateral, if so required, provided such pledge is also consistent with the Interest Rate Swap Policy.

3. The Corporation is authorized to pledge its receivables and other items of revenue to secure Obligations issued under the Master Indenture.

4. A Plan of Finance Committee is hereby established, consisting of the Chairman of the Finance Committee, a second member to be designated by the Finance Committee and acting in consultation with the Executive Vice President/Chief Financial Officer, with authority to approve the final terms of the Plan of Finance, including (but not limited to) the aggregate principal amount of indebtedness incurred under the Loan Agreement and the SWEEP Loan Agreement, the maturities of the Series 2005 Bonds and the amortization of the loans under the Loan Agreement and the SWEEP Loan Agreement, the interest rates on the Series 2005 Bonds and under the SWEEP Loan Agreement (or the manner by which interest rates are determined on a variable rate basis), the purchase price to be paid by Citigroup for the Series 2005 Bonds, including in the price the effect of its underwriter discount or fee, the premium to be paid the Bond Insurer and the

selection of the Bond Insurer, the selection of the bond trustee, and such other matters as are associated with incurring indebtedness or issuing securities in the capital markets.

5. Each of the Authorized Officers shall be and is hereby authorized, empowered and directed to execute, enter into and deliver for, and in the name and on behalf of the Corporation and, if required, duly attested by the Secretary or an Assistant Secretary of the Corporation, all documents as may be necessary to effectuate the transactions described herein, including those described herein, such documents to be in a form satisfactory to the Authorized Officer executing the same on behalf of the Corporation, and the execution of such documents by such Authorized Officer shall constitute conclusive evidence of such Authorized Officer's approval and the Board's approval thereof, as well as the approval of other documents to which the Corporation is not a party that are necessary and proper for implementation of the Plan of Finance.

6. The Corporation is authorized to execute and deliver Obligations to the parties and for the purposes described herein.

7. All actions of the officers and management of this Corporation toward the development and implementation of the Plan of Finance, to the extent consistent with these Resolutions, are hereby ratified and approved.

CALIFORNIA NURSES ASSOCIATION

AN URGENT MESSAGE FROM SCRIPPS ENCINITAS NURSES

March 17th, 2005

Dear Scripps Donors and Community Members:

We hope the following information is helpful in explaining why Scripps Encinitas nurses have chosen to join the California Nurses Association.

> **A patient's risk of avoidable death increases by 7% for every additional patient on an RN's workload** (*Journal of American Medicine, October 23-30, 2002*).
>
> **A higher proportion of hours of nursing care provided by RNs and a greater number of hours of care by RNs are associated with better outcomes for hospital patients, and lower rates of pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis or deep venous thrombosis. No similar association exists for LVNs or other nursing staff.** (*New England Journal of Medicine May 30, 2002*).
>
> **Staffing levels have been a factor in 24% of the 1,609 sentinel events – unanticipated events that result in death, injury or permanent loss of function – reported to JCAHO in the past 5 years.** (*JCAHO report, August 7, 2002*)

34% of the 250 RNs at Scripps Encinitas have less than 2 years of service. 59% have less than 5 years at the hospital. RNs are leaving this hospital almost as fast as new ones are hired. THE REVOLVING DOOR NEEDS TO CEASE. **From March to November 2004, according to information provided by Scripps management, 34 RNs were hired and 28 RNs left.**

The hospital is not providing the conditions necessary to recruit and retain skilled registered nurses. Instead, they have increased the usage of "TEMP" RNs at costs that are sometimes DOUBLE the rates paid to staff RNs. Last year, Scripps Encinitas spent over $3 MILLION on "TEMP" Nursing staff. **Recent studies have revealed that there is an increase in negative patient outcomes associated with temporary nursing staff**. We have found this to be true at Scripps Encinitas.

The hospital has also increased the hiring of inexperienced LVNs in the Emergency Room and on other units. LVNs have less training and a different scope of practice than RNs. They cannot legally assess a patient's condition nor give IV medications. Care has suffered as a result, and this has contributed to RN demoralization.

Yet, in bargaining the hospital has not agreed to a Staff Nurse Run Patient Care Committee that is driven by PATIENT NEED instead of budget. There is little cost associated with the PPC, and CNA has these committees at other hospitals. Where PPCs exist, the quality of patient care has improved, and the number of medical errors have decreased.

There is great disparity in pay between nurses with the same years of experience. Yet, the hospital insists on a compressed pay structure that is below the San Diego community standard for experienced RNs and has refused to eliminate "Subjective Merit Pay" that has silenced RNs from their duty as patient advocates and caused the current disparity in pay.

In addition they have rejected Union Membership which gives RNs the power and unity to effectively advocate for their patients, even though the overwhelming majority of RNs have voiced their strong support.

Scripps Encinitas has almost three (3) times the vacancy rate as UCSD and Palomar Pomerado, both of which have a CNA contract which reflects the RN's value to the institution. At UCSD and Palomar, there are safe staffing protections, competitive salary steps and union membership provisions which have led to lower turnover rates. (See recent San Diego Union Tribune article).

Nurses rejected management's final offer by a vote of 94%. We have no choice but to take assertive actions on behalf of our patients.

Scripps Encinitas RNs have made it clear that we will not stand by and watch management's attack on nurses' rights and on patient care, especially during a dramatic shortage of nurses. This is not just a labor dispute. It is a patient care crisis in the making. Scripps Encinitas nurses need your help in sending this message to Chris Van Gorder, CEO, Scripps Health and Carl Etter, CEO, Scripps Encinitas Hospital.

WE ASK THAT YOU EXPRESS YOUR SUPPORT FOR THE RNS @ SCRIPPS ENCINITAS BY BOTH PLACING A CALL AND WRITING A LETTER TO:

CHRIS VAN GORDER, CEO, Scripps Health, 4275 Campus Point Court, San Diego, CA 92121; phone: (858) 678-7000 &
CARL ETTER, CEO, Scripps Encinitas, 354 Santa Fe Drive, Encinitas, CA, 92024; phone: (760) 633-7699 office, (760) 846-0302 (cell)

Send a copy of your correspondence to us c/o CNA, 425 W. Broadway, #111; Glendale, California 91204, or email a copy to dgarcia@calnurses.org;

Sincerely,

The Scripps Encinitas CNA Nurse Negotiating Team

Mike Pigott, RN, ICU
Melissa Clark, RN, 2 North
Renee Menard, RN, Emergency Department
Steve Nyeholt, RN, ICU

Cc: Scripps Encinitas Facility Bargaining Council

If you have questions, do not hesitate to call us.

Scripps

VII. FINANCIAL INFORMATION:

Tab 8

A. Briefly discuss any substantive year-to-year changes or trends in the Applicant's revenues and expenditures and assets and liabilities for the prior three years. Provide for only the Obligated Group, if financing is part of a master indenture. Also, briefly discuss management's financial outlook for the health facility (or Obligated Group) over the next three years.

A key part of the mission of Scripps Health is to provide quality health care services to the communities it serves. To sustain and enhance that mission, Scripps Health's focus is on maintaining a positive operating margin while establishing a cash and investments balance to overcome economic uncertainty, change in the health care industry, and provide the capital resources necessary for technological change and facility upgrading requirements.

See "Management's Discussion and Analysis of Results of Operations and Financial Condition" in the attached "Appendix A."

B. Provide copies of the Applicant's consolidated audited financial statements for the three most recent fiscal years and the most recent consolidated year-to-date interim financial statements. Provide for only the Obligated Group, if financing is part of a master indenture.

See following pages.

C. Briefly discuss the potential affects to your operations of federal and state proposals for managed care. Further discuss your past progress and future plans to respond to the proposals.

NOT APPLICABLE

KPMG

SCRIPPS HEALTH

Consolidated Financial Statements

September 30, 2004 and 2003

(With Independent Auditors' Report Thereon)

SCRIPPS HEALTH

Consolidated Financial Statements

September 30, 2004 and 2003

Table of Contents

KPMG LLP
Suite 2000
355 South Grand Avenue
Los Angeles, CA 90071-1568

Independent Auditors' Report

The Board of Trustees
Scripps Health:

We have audited the accompanying consolidated statements of financial position of Scripps Health as of September 30, 2004 and 2003, and the related consolidated statements of operations, changes in equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Scripps Health's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Scripps Health as of September 30, 2004 and 2003, and the results of their operations, their changes in equity, and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were made for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

KPMG LLP

December 3, 2004

SCRIPPS HEALTH

Consolidated Statements of Financial Position

September 30, 2004 and 2003

(In thousands)

Assets	2004	2003
Current assets:		
Cash and cash equivalents	$ 66,862	38,228
Accounts receivable, net	178,235	184,561
Other current assets	54,732	39,819
Total current assets	299,829	262,608
Investments	354,550	323,639
Property, plant, and equipment, net	473,082	458,504
Other assets	124,439	130,156
Total assets	$ 1,251,900	1,174,907
Liabilities and Equity		
Current liabilities:		
Current portion of long-term debt	$ 7,746	27,640
Accounts payable	60,286	52,793
Accrued liabilities	160,374	140,379
Total current liabilities	228,406	220,812
Long-term debt	309,648	315,682
Other liabilities	45,683	41,086
Commitments and contingencies (notes 3, 6, 8, 11, 14, and 15)		
Total liabilities	583,737	577,580
Equity:		
Unrestricted	535,913	469,251
Temporarily restricted	75,832	72,163
Permanently restricted	56,418	55,913
Total equity	668,163	597,327
Total liabilities and equity	$ 1,251,900	1,174,907

See accompanying notes to consolidated financial statements.

SCRIPPS HEALTH

Consolidated Statements of Operations

Years ended September 30, 2004 and 2003

(In thousands)

	2004	2003
Revenues:		
Healthcare delivery	$ 1,264,142	1,159,917
Other operating revenue	50,678	63,116
Investment income	12,585	8,874
Contributions	1,581	1,304
Gain on sale of property	206	704
Equity released from restrictions used for operations	23,476	18,674
Total revenues	1,352,668	1,252,589
Expenses:		
Wages and benefits	587,978	551,276
Supplies	255,713	238,829
Services	346,175	341,692
Provision for uncollectible accounts receivable	58,354	41,770
Depreciation and amortization	53,204	48,860
Interest	10,194	10,550
Other than temporary decline in investments	—	1,164
Total expenses	1,311,618	1,234,141
Operating gain	41,050	18,448
Other gains, net	25,612	27,685
Net increase in unrestricted equity	$ 66,662	46,133

See accompanying notes to consolidated financial statements.

SCRIPPS HEALTH

Consolidated Statements of Changes in Equity

Years ended September 30, 2004 and 2003

(In thousands)

	2004	2003
Unrestricted equity:		
Operating gain	$ 41,050	18,448
Other changes affecting unrestricted equity:		
Unrealized gains on investments	17,170	25,368
Equity released from restrictions used for purchases of property and equipment	7,033	2,256
Other	1,409	61
Increase in unrestricted equity	66,662	46,133
Temporarily restricted equity:		
Contributions	26,145	22,789
Investment income	2,675	2,130
Unrealized gains on investments	5,868	6,402
Equity released from restrictions used for operations	(23,476)	(18,674)
Equity released from restrictions used for purchases of property and equipment	(7,033)	(2,256)
Change in value of deferred gifts	(510)	18
Increase in temporarily restricted equity	3,669	10,409
Permanently restricted equity:		
Contributions	2,785	3,043
Change in value of deferred gifts	(2,280)	(900)
Increase in permanently restricted equity	505	2,143
Total increase in equity	70,836	58,685
Equity at beginning of year	597,327	538,642
Equity at end of year	$ 668,163	597,327

See accompanying notes to consolidated financial statements.

SCRIPPS HEALTH

Consolidated Statements of Cash Flows

Years ended September 30, 2004 and 2003

(In thousands)

	2004	2003
Cash flows from operating activities:		
Net increase in equity	$ 70,836	58,685
Reconciliation of net increase in equity to cash provided by (used in) operating activities:		
Depreciation and amortization	53,204	48,860
Provision for uncollectible accounts receivable	58,354	41,770
Other than temporary decline in investments	—	1,164
Realized and unrealized gains on investments	(31,725)	(34,799)
Gain on sale of property	(206)	(704)
Restricted contributions and investment income	(30,541)	(27,918)
Changes in assets and liabilities:		
Accounts receivable, net	(52,028)	(78,180)
Other current assets	(14,913)	(1,919)
Other assets	11,408	(1,343)
Accounts payable and accrued liabilities	24,062	(7,548)
Other liabilities	4,597	(2,878)
Net cash provided by (used in) operating activities	93,048	(4,810)
Cash flows from investing activities:		
Proceeds from sale of investments	169,626	124,518
Purchases of investments	(168,812)	(126,753)
Proceeds from sale of property	725	1,034
Principal payments on note receivable received	112	107
Purchases of property, plant, and equipment	(64,875)	(39,159)
Net cash used for investing activities	(63,224)	(40,253)
Cash flows from financing activities:		
Restricted contributions and investment income	24,738	28,082
Proceeds from line of credit	—	20,000
Payments on line of credit	(20,000)	—
Proceeds from note payable	1,821	—
Payments on long-term debt	(7,749)	(8,069)
Net cash provided by (used in) financing activities	(1,190)	40,013
Increase (decrease) in cash and cash equivalents	28,634	(5,050)
Cash and cash equivalents at beginning of year	38,228	43,278
Cash and cash equivalents at end of year	$ 66,862	38,228
Supplemental cash flow information:		
Cash paid during the year for interest	$ 10,348	10,457

See accompanying notes to consolidated financial statements.

(1) Organization and Nature of Operations

Scripps Health is a California not-for-profit public benefit corporation that provides healthcare services through a network of hospitals and related healthcare operations located in San Diego County.

The consolidated financial statements for Scripps Health include the financial position and results of operations of Scripps Clinic, operated by Scripps Health as a 1206(1) foundation, Scripps Clinic Physicians Organization (SCPO), Scripps Clinic Health Plan Services (SCHPS), a wholly owned subsidiary of SCPO and California corporation that was granted a license under the Knox-Keene Health Care Service Plan Act to operate as a healthcare service plan in California, and The Whittier Institute for Diabetes (TWI), a not-for-profit public benefit corporation formed to provide research, education, and patient care in the field of diabetes.

The entities of Scripps Health, with the exception of SCPO and SCHPS, are exempt from federal income taxes under Section (501)(c)(3) of the Internal Revenue Code and are exempt from state income taxes under Section 237(d) of the California Revenue and Taxation Code.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying consolidated financial statements include the accounts of the entities that Scripps Health controls. All significant transactions between these entities have been eliminated in the accompanying consolidated financial statements.

(b) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include: the carrying amounts for goodwill, property, plant and equipment, and covenant not-to-compete; valuation of deferred gifts; valuation allowances for receivables; and liabilities for claims incurred but not reported under capitation agreements and self-insured programs. Actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Scripps Health considers highly liquid investments with maturities of three months or less, excluding those whose use is limited, to be cash equivalents.

(d) Property and Other Long-Lived Assets

Property, plant, and equipment and other long-lived assets are recorded at cost when purchased or at fair market value if contributed. Depreciation and amortization of assets are recorded on a straight-line basis over the period in which the assets are estimated to be in service and of value to

(Continued)

the organization. The amount of impairment, if any, is recognized when it is determined that the carrying amount of the asset is not recoverable. The amount of impairment is measured based upon the difference between the carrying value and fair value of the asset.

(e) Goodwill

Goodwill, which represents the excess of purchase price over fair value of net assets acquired, is amortized on a straight-line basis over the expected periods to be benefited, generally 25 years. Scripps Health assesses the recoverability of this intangible asset by determining whether the amortization of the goodwill balance over its remaining life can be recovered through undiscounted future operating cash flows of the acquired operation. The amount of goodwill impairment, if any, is measured based on projected discounted future operating cash flows using a discount rate reflecting Scripps Health's average cost of funds. The assessment of the recoverability of goodwill will be impacted if estimated future operating cash flows are not achieved.

(f) Impairment of Long-Lived Assets

Long-lived assets, such as property, plant, and equipment and purchased intangibles subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset.

(g) Cost of Borrowing

Interest expense is recorded as incurred; however, when money is borrowed for construction or renovation of facilities, the interest cost on that debt during the period of construction is capitalized as part of the asset. Any interest income earned on borrowed funds during construction is accounted for as a reduction of interest cost. Costs associated with issuing debt are capitalized and amortized by the straight-line method, which approximates the effective-interest method, over the term of the debt.

(h) Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated statements of financial position. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in operating gain unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from operating gain. A decline in the market value of a security below cost that is deemed to be other than temporary results in a reduction in carrying amount to fair value. The impairment is charged to operating gain and a new cost basis for the security is established.

(Continued)

(i) Contributions and Restricted Equity

Contributions are recorded at estimated fair value as of the date the contribution is received. Unconditional promises (pledges) to contribute assets are recorded at fair value at the date the promise is received. Pledges and other deferred gifts are discounted to their net present value. In addition, gifts received as irrevocable trusts, which usually provide for payments to the donor until the donor's death, are reduced by the present value of estimated payments to the donor.

Contributions that are not restricted as to use are reported as unrestricted revenue in the consolidated statements of operations. If the donor restricts the use of the gift, contributions are reported as increases in temporarily or permanently restricted equity in the consolidated statements of changes in equity.

Temporarily restricted contributions are generally limited by a time or a specific purpose restriction. When restrictions are met, temporarily restricted equity is transferred to unrestricted equity and recorded as equity released from restrictions in the consolidated statements of operations.

Permanently restricted contributions have been restricted by donors to be maintained in perpetuity. Income from such gifts is recorded as temporarily restricted equity and transferred to unrestricted equity when restrictions are met.

(j) Healthcare Revenue and Accounts Receivable

Healthcare delivery revenue consists primarily of: (1) patient service revenue provided under contracts with various government-sponsored healthcare programs (Medicare and Medi-Cal), insurance companies, and other third parties and (2) capitation premium revenue received under contracts with managed care payors.

Patient service revenue is recognized as services are delivered. Contracts usually involve discounts from established rates. Payment arrangements consist of prospectively determined rates per discharge, discounted charges, per diem payments, and reimbursed costs. Scripps Health is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual Medicare cost reports by Scripps Health and audits thereof by the fiscal intermediary.

Revenue and related receivables are recorded net of contractual discounts. Provisions for uncollectible receivables are recorded as operating expenses. Provisions for contractual discounts and uncollectible accounts are estimated based upon an evaluation of historical collection experience. Adjustments and changes in estimates are recorded in the period in which they are determined.

Capitation premium revenue is recognized during the period enrollees are entitled to receive services. This is generally calculated and paid to Scripps Health as a fixed premium per enrollee (member) per month. Therefore, there are no accounts receivable from patients related to these types of contracts.

Scripps Health provides healthcare services without charge to patients who meet criteria under its charity care policy. Such services are not reported as revenue.

(Continued)

(k) Unbilled Services and Deferred Revenue

Scripps Health is engaged in contractual research activities and continuing medical education programs. The majority of the contracts have a fixed budget with some variable components and range in duration from a few months to several years. Generally, a portion of the contract fee is paid at the time the contract is initiated with performance-based installments payable over the contract duration. In general, prerequisites for billings are established by contractual provisions, including predetermined payment schedules, the achievement of contract milestones, or submission of appropriate billing detail. Unbilled services arise when services have been rendered but clients have not been billed. Similarly, deferred revenue represents cash receipts for services that have not been rendered. Scripps Health recognizes net revenue from its contracts on a percentage-of-completion method, based primarily on contract costs incurred to date compared to total estimated contract cost. Management believes that this methodology appropriately reflects revenue for clinical trials in the period in which services are provided.

(l) Cost of Healthcare Services

The cost of healthcare services is recognized in the period in which services are delivered. Under capitation contracts, Scripps Health is responsible for the costs of certain services delivered to enrollees, but may not always be the provider of those services. Scripps Health accrues expense for costs incurred but not yet reported (IBNR) by outside providers using historical studies of claims paid and trend factors. IBNR at September 30, 2004 and 2003 was $12,012,000 and $13,397,000, respectively, and is included in accrued liabilities in the consolidated statements of financial position.

(m) Operating Gains

The consolidated statements of operations reflect all activity of Scripps Health except for changes to temporarily or permanently restricted equity. Contributions and investment income related to temporarily and permanently restricted equity are reported in the consolidated statements of changes in equity.

Unrealized gains and losses on investments and equity released from restrictions used for the purchase of property and equipment are included as changes in unrestricted equity but are excluded from operating gains.

(n) Income taxes

Scripps Health accounts for income taxes related to the operations of its for-profit subsidiaries (SCPO and SCHPS) under the provisions of SFAS No. 109, *Accounting for Income Taxes*.

(o) Reclassifications

Certain items in the prior year consolidated financial statements have been reclassified to conform to the current year presentation.

(Continued)

(3) Affiliation with Catholic Healthcare West

In August 1995, Scripps Health and Catholic Healthcare West (CHW) entered into an affiliation agreement to enhance their mutual ability to serve the San Diego community. Through the affiliation, CHW transferred the sole voting membership of one of its subordinate corporations, Mercy Healthcare San Diego (MHSD), to Scripps Health, along with the responsibility for its operations and governance. MHSD's principal activity is the operation of a hospital and a network of clinics.

Pursuant to the affiliation agreement, CHW, among other things, obtained the right to receive a 20% interest in the annual change in unrestricted net equity of Scripps Health and the right to 20% of the net proceeds, with certain restrictions, upon the liquidation of Scripps Health. Scripps Health has the right to receive from CHW an amount equal to CHW's percentage interest in (i) the annual capital expenditures of Scripps Health and (ii) the annual amortization of debt principal of Scripps Health. Scripps Health and CHW may make an election annually to receive all or a portion of the accumulated but not previously paid amounts under the affiliation agreement, subject to certain conditions. No payments have ever been paid by either party under these provisions and as of September 30, 2004 no amounts are due. Of the members of the Scripps Health Board of Trustees, 20% are required to be elected from a slate of nominees proposed by CHW.

Under the terms of the affiliation agreement, Scripps Health is required to contribute $2,000,000 per year, adjusted annually for inflation, to a Strategic Capital Reserve Pool (the Pool), up to a maximum aggregate contribution of $20,000,000, and such contributions have been made annually. Funds in the Pool may be used to undertake capital projects that are of mutual benefit to Scripps Health and CHW in support of healthcare in the San Diego community. Projects funded through the Pool require the approval of both Scripps Health and CHW. As of September 30, 2004 and 2003, the balance in the Pool is $9,800,000 and $10,200,000, respectively, and is included in other assets in the accompanying consolidated statements of financial position (note 7).

(4) Healthcare Delivery Revenue and Accounts Receivable

Healthcare delivery revenue for the years ended September 30, 2004 and 2003 consisted of the following:

	2004	2003
	(In thousands)	
Patient service revenue	$ 1,073,785	979,793
Capitation premium revenue	190,357	180,124
	$ 1,264,142	1,159,917

(Continued)

Accounts receivable relating to patient service revenue consisted of the following payor mix at September 30, 2004 and 2003:

	2004	2003
Medicare	17%	17%
Medi-Cal	11	9
HMO/PPO payors	44	46
Other third-party payors	6	8
Patient responsibility	22	20
	100%	100%

Accounts receivable are presented net of an allowance for doubtful accounts of $39,857,000 and $31,638,000 at September 30, 2004 and 2003, respectively. An estimated net third-party settlement payable of $8,893,000 and $10,059,000 is included in accrued liabilities at September 30, 2004 and 2003, respectively.

Capitation contracts with managed care payors generally provide for terms of one to three years, with automatic renewal periods terminable on prior notice by either party. Scripps Health has agreements with various third parties that govern how financial risk is shared. Estimated amounts to be paid or received under risk-sharing arrangements have been accrued as of September 30, 2004 and 2003.

The estimated cost of providing charity care was $18,194,000 for fiscal 2004 and $13,881,000 for fiscal 2003. In addition, Scripps Health accepts patients for which it is reimbursed under various county, state, and federal indigent care programs at amounts that do not cover the cost of healthcare services provided. The estimated cost of providing such underreimbursed care is $15,680,000 for fiscal 2004 and $19,282,000 for fiscal 2003. These amounts are net of Medi-Cal disproportionate share receipts of $18,195,000 and $12,877,000 for fiscal years 2004 and 2003, respectively. Community benefits also provided by Scripps Health include the cost of health education, health clinics and screenings, and medical research. The cost of such benefits for the broader community is not included in the charity care or underreimbursed care amounts above.

(Continued)

(5) Investments

Investments, stated at fair market value at September 30, 2004 and 2003, are summarized below:

	2004	2003
	(In thousands)	
Fixed income securities	$ 133,260	133,330
Equity securities	190,431	148,600
Money market funds and certificates of deposit	42,609	50,782
	366,300	332,712
Less debt service funds held by trustees, required to pay current liabilities, included in other current assets	11,750	9,073
	$ 354,550	323,639

The use of certain investments is limited as follows:

	2004	2003
	(In thousands)	
Assets included in restricted equity	$ 90,946	88,812
Unexpended and reserve bond funds held by trustees	7,238	9,689
Assets held in trust for supplemental retirement plans	4,263	4,128
	$ 102,447	102,629

The composition of investment return for the years ended September 30, 2004 and 2003 includes the following:

	2004		
	Unrestricted	Temporarily restricted	Total
		(In thousands)	
Interest and dividends	$ 4,962	1,611	6,573
Net realized gains	7,623	1,064	8,687
Net unrealized gains	17,170	5,868	23,038
	$ 29,755	8,543	38,298

(Continued)

	2003		
	Unrestricted	Temporarily restricted	Total
		(In thousands)	
Interest and dividends	$ 5,889	2,086	7,975
Net realized gains	2,985	44	3,029
Net unrealized gains	25,368	6,402	31,770
Other than temporary decline in investments	(1,164)	—	(1,164)
	$ 33,078	8,532	41,610

Included in the investments listed below are certain securities that had incurred an unrealized loss as of September 30, 2004. The unrealized losses occurred as a result of fluctuations in the financial markets and a generally rising interest rate environment. Scripps Health continues to hold these securities as part of its long-term investment strategy and believes the market values will ultimately recover. These individual securities have been aggregated by investment category and length of time that they have been in a continuous unrealized loss position:

	Less than 12 months		12 months or more		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
			(In thousands)			
Fixed income securities	$ 17,736	107	—	—	17,736	107
Equity securities and mutual funds	9,229	1,043	29,130	2,101	38,359	3,144
Total	$ 26,965	1,150	29,130	2,101	56,095	3,251

(6) Property, Plant, and Equipment

Property, plant, and equipment at September 30, 2004 and 2003 are summarized below:

	Useful lives	2004	2003
		(In thousands)	
Land	—	$ 73,447	73,994
Buildings and improvements	5 to 40 years	537,268	523,622
Equipment	5 to 15 years	368,353	339,239
Construction in progress	—	39,147	22,305
		1,018,215	959,160
Less accumulated depreciation		545,133	500,656
Property, plant, and equipment, net		$ 473,082	458,504

(Continued)

Construction in progress at September 30, 2004 and 2003 is related to various renovation projects. The total estimated completion cost of those projects is $54,762,000 at September 30, 2004. In addition, there are outstanding purchase commitments totaling $787,000 at September 30, 2004.

(7) **Other Assets**

Other assets at September 30, 2004 and 2003 are summarized below:

	2004	2003
	(In thousands)	
Deferred gifts:		
Annuity and unitrust accounts (primarily equity securities stated at fair market value)	$ 32,222	35,033
Land held in trust	16,913	19,372
Pledges receivable, net	11,402	5,599
Other assets included in restricted equity	60,537	60,004
Covenant not-to-compete, net	994	2,200
Deferred compensation, net	923	2,016
Goodwill, net	41,847	43,922
Notes receivable	2,368	2,438
Debt issuance costs, net	7,247	7,630
Strategic capital reserve pool (note 3)	9,833	10,185
Other	690	1,761
	$ 124,439	130,156

The amount of unconditional promises receivable at September 30, 2004 and 2003 is as follows:

	2004	2003
Unconditional promises to give	$ 16,174	9,984
Less allowance for uncollectible pledges	4,220	4,183
Less unamortized discount	552	202
Net unconditional promises to give	$ 11,402	5,599
Amounts due in:		
Less than one year	$ 5,628	360
One to five years	5,774	5,239
Total	$ 11,402	5,599

The fair value of these pledges was determined by calculating the net present value of the estimated future cash flows using discount rates at the date of the pledge ranging from 1.7% to 6.6%.

Other assets included in restricted equity are principally deferred gifts that are temporarily restricted because of a time restriction. Once this time restriction has been met, they are generally available for unrestricted use.

(Continued)

(8) Long-Term Debt

A summary of long-term debt at September 30, 2004 and 2003 follows:

	2004	2003
	(In thousands)	
Tax-exempt bonds sponsored by the California Health Facilities Financing Authority (CHFFA):		
Variable rate bonds:		
Series 2001A, principal due in varying installments commencing October 2002 through October 2023; interest payable monthly, at a variable rate (1.7% at September 30, 2004)	$ 56,850	59,250
Series 1998A and B, principal due in varying annual installments commencing October 2004 through October 2022; Series A ($32,500,000) and Series B ($32,500,000) interest payable monthly at a variable rate (1.6% at September 30, 2004)	65,000	65,000
Series 1991B due October 2021; principal due in varying installments; interest payable monthly at a variable rate (1.6% at September 30, 2004)	31,500	31,500
Series 1985B, principal due in varying annual installments commencing December 2006 through December 2015; interest payable monthly at a variable rate (1.6% at September 30, 2004)	53,100	53,100
	206,450	208,850
Fixed rate bonds:		
Series 1998C, principal due in varying annual installments commencing October 2004 through 2022; interest payable semiannually at fixed rates ranging from 4.5% to 5.0%	40,230	40,230
Series 1993A, principal due in varying annual installments through October 2018; interest payable semiannually at fixed rates ranging from 4.7% to 4.8%	9,340	9,765
Series 1992A, principal due in varying annual installments through October 2022; interest payable semiannually at fixed rates ranging from 6.2% to 6.4%	34,875	35,815
Series 1991A due October 2013; principal due in varying installments; interest payable semiannually at a fixed rate of 6.25%	21,200	22,760
	105,645	108,570
Total tax-exempt bonds	312,095	317,420

(Continued)

	2004	2003
	(In thousands)	
Series 1993 taxable bonds, principal due in varying installments through October 2013; interest payable semiannually at a fixed rate of 7.3%	$ 3,455	5,535
Line of credit, renewable on April 7, 2007, with interest payable monthly at a variable rate	—	20,000
Other	1,844	367
Total	317,394	343,322
Less current portion	7,746	27,640
Total long-term debt	$ 309,648	315,682

Scheduled principal repayments of long-term debt for the next five fiscal years and thereafter are as follows (in thousands):

Year:	
2005	$ 7,746
2006	10,911
2007	12,628
2008	12,177
2009	12,697
Thereafter	261,235
	$ 317,394

Scripps Health has entered into credit facilities totaling $206.4 million with various banking institutions to fund optional tenders from bondholders. Liquidity facilities are meant to provide support in times of market disruption, which can be internally or externally driven. There were no draws on the various liquidity facilities in 2004 and 2003. These credit facilities are secured by a Master Obligation that is issued under the Master Indenture of Trust (Indenture) dated as of December 1, 1985 and amended and restated May 1, 1998, which encompasses substantially all of Scripps Health's outstanding debt obligations. All bonds, with the exception of the 2001A bonds which are guaranteed by a letter of credit, are guaranteed by a bond insurer, subject to provisions of the Indenture.

Under the terms of the Master Indenture of Trust and the Letter of Credit Reimbursement Agreement, Scripps Health is required to meet certain financial ratios. The Indenture also places limits on Scripps Health's ability to obtain additional borrowings. The obligations under the master indenture are not secured by any pledge of, mortgage on, or security interest in the assets or revenues of Scripps Health.

(Continued)

The interest rates on variable debt are reset weekly by the remarketing agent in accordance with the Indenture depending on prevailing market conditions. The rates are highly correlated with the Bond Market Municipal Swap Index. The average interest rate on variable debt was 1.03% for fiscal 2004 and 0.92% for 2003, respectively.

Scripps Health maintains a credit facility arrangement which includes a revolving line of credit of $47,000,000. The revolving credit facility expires on April 7, 2007, but may be extended from time to time. Amounts outstanding under this revolving line of credit at September 30, 2004 and 2003 were $0 and $20,000,000, respectively.

Based on the borrowing rates currently available to Scripps Health for loans with similar terms and maturities, the estimated fair value of long-term debt was approximately $319,863,000 and $327,368,000 at September 30, 2004 and 2003, respectively (see note 18).

(9) Other Liabilities

Other liabilities at September 30, 2004 and 2003 are summarized below:

	2004	2003
	(In thousands)	
Accrued liability for professional self-insurance (discounted at 6.5%)	$ 20,829	14,849
Annuity/unitrust liabilities (discounted at 5% in 2004 and 6% in 2003)	17,060	18,790
Deferred retirement liability	6,393	5,607
Other	1,401	1,840
	$ 45,683	41,086

(10) Scripps Clinic

In fiscal 2000, Scripps Health acquired all the outstanding shares of SCPO and its wholly owned subsidiaries and substantially all the assets and liabilities of Scripps Clinic Medical Group (SCMG). As a result of the acquisition, the excess of purchase price over the fair value of assets acquired (goodwill) has been recorded in the consolidated financial statements in the amount of $49,692,000 and is being amortized, on a straight-line basis, over 25 years. Accumulated amortization of goodwill totaled $8,369,000 and $6,294,000 for fiscal years 2004 and 2003, respectively.

As part of the acquisition, Scripps Health entered into a restrictive covenant agreement with the former physician shareholders of SCPO and agreed to put $6,000,000 in a separate fund to be paid at the end of five years. These funds are to be paid, pro rata, to the former shareholders who do not compete with Scripps Health during the five-year period from the date of acquisition. Accumulated amortization totaled $5,006,000 and $3,800,000 for fiscal years 2004 and 2003, respectively.

Additionally, Scripps Health entered into a Provider Services Agreement (PSA) with SCMG whereby SCMG agreed to provide physician services to patients of Scripps Health for a period of 25 years, with renewal for up to three additional 25-year terms. Under the PSA, compensation to be paid by Scripps

(Continued)

Health for these services is calculated based on a predetermined formula at the commencement of the PSA that was effective through July 14, 2002. The compensation provisions of the PSA were renegotiated in September 2004 to be effective January 1, 2005 through December 31, 2006, except for certain terms which were retroactive to January 1, 2004. The compensation agreement includes a deferred benefit of $5,512,000, net of forfeitures of $488,000, to the physicians, which is subject to a covenant not-to-compete during the five-year period from the date of acquisition. Accumulated amortization totaled $4,589,000 and $3,496,000 for fiscal years 2004 and 2003, respectively.

(11) Lease Commitments

Scripps Health leases various equipment and facilities under operating leases expiring at various dates through 2043. Total rental expense was $16,978,000 and $15,298,000 for the years ended September 30, 2004 and 2003, respectively. The following is a schedule of future minimum lease payments as of September 30, 2004 under operating leases that have initial or remaining terms in excess of one year:

	Facilities	Equipment	Total
		(In thousands)	
Year:			
2005	$ 10,763	406	11,169
2006	11,103	73	11,176
2007	10,791	18	10,809
2008	9,559	—	9,559
2009	7,656	—	7,656
Thereafter	88,378	—	88,378
	$ 138,250	497	138,747

(12) Rental Income

Scripps Health leases medical office space to various physicians and other healthcare related entities under operating leases. The leases provide for minimum rentals and additional amounts for real estate taxes and common area expenses. Total rental income was $9,982,000 and $8,089,000 for the years ended September 30, 2004 and 2003, respectively. The following is a schedule of future minimum rentals receivable as of September 30, 2004 under operating leases that have initial or remaining terms in excess of one year (in thousands):

Year:	
2005	$ 6,835
2006	5,188
2007	3,918
2008	3,467
2009	1,627
Thereafter	7,526
	$ 28,561

(Continued)

(13) Temporarily and Permanently Restricted Equity

Temporarily restricted equity is available for the following purposes or periods as of September 30, 2004 and 2003:

	2004	2003
	(In thousands)	
Healthcare operations – specific purpose	$ 11,889	9,752
Research	16,838	17,722
Education	7,758	4,211
Building construction and equipment	11,548	5,514
Indigent care	1,518	3,794
Deferred gifts, available for use in future periods	26,281	31,170
	$ 75,832	72,163

During fiscal years 2004 and 2003, temporarily restricted equity of $30,509,000 and $20,930,000, respectively, were released from restrictions by incurring expenditures that satisfied the donor's purpose or time restriction.

Permanently restricted equity at September 30, 2004 and 2003 are restricted to investments in perpetuity, the income from which is expendable to support:

	2004	2003
	(In thousands)	
Healthcare operations	$ 24,390	25,493
Research	14,230	15,953
Education	10,064	7,274
Indigent care	3,621	3,621
Purchase of equipment	1,078	1,077
Deferred gifts, the income from which will be available for use in future periods	3,035	2,495
	$ 56,418	55,913

(14) Risk Management and Contingencies

(a) Insurance Coverage

Scripps Health is self-insured for hospital professional and hospital general liability risks for the first $1.5 million of loss per occurrence and 50% of the second $1 million of loss per occurrence. Losses in excess of this amount are insured through claims-made professional liability policies that provide coverage to a maximum of $50 million per occurrence subject to a $50 million aggregate. The provision for estimated self-insured professional liability claims includes estimates of the ultimate liability and defense costs for both reported claims and incurred but not reported claims.

(Continued)

Scripps Health is also self-insured for workers' compensation risks for the first $1 million of loss per occurrence. Losses in excess of this amount are insured through policies of insurance which provide coverage up to statutory amounts.

SCHPS is insured for Managed Care Liability through a primary policy with limits of $2,000,000 per occurrence and $2,000,000 annual aggregate and is insured through excess policies for an additional $50 million per occurrence and $50 million aggregate.

Scripps Clinic is insured through a master policy with SCMG on a claims-made basis and Scripps Health is acknowledged as an administrative insured of this policy. Professional liability coverage is provided for Scripps Health employees with limits of $5 million per occurrence and $10 million in the annual aggregate subject to a self-insured retention of $500,000 per claim and $2.9 million ($2.7 million in 2003) per year in the aggregate. Claims-made coverage covers only those claims reported during the policy period and Scripps Health records an accrual for losses incurred but not reported. Excess policies provided additional insurance in the amount of $50 million per occurrence and $50 million annual aggregate.

Scripps Health is self-insured for employee health benefits. Scripps Health records an accrual for claims incurred but not reported.

(b) Legal

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medi-Cal programs, is subject to government review and interpretation, as well as regulatory actions. Claims for payment for services rendered to Medicare and Medi-Cal beneficiaries must meet applicable billing laws and regulations, which, among other things, require that the services are medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records. Allegations concerning possible violations of regulations can result in the imposition of significant fines and penalties, as well as significant repayment of previously billed and collected revenues for patient services.

The Office of Inspector General of the U.S. Department of Health and Human Services (the OIG) has performed an audit of a Scripps Health outpatient psychiatric care program (the Program) for the year ended September 30, 1997. The OIG has reviewed a sample of medical records of Medicare patients of the Program and issued a report alleging that some services provided to Medicare patients of the Program were not medically necessary and therefore not reimbursable.

In September 2002, the Medicare fiscal intermediary issued an audited cost report for fiscal 1997 which included the OIG's recommended adjustments relative to medical necessity. Scripps Health paid $1.7 million pursuant to this audited cost report. Scripps Health appealed the aforementioned adjustments and an administrative law judge ordered repayment of the $1.7 million, which was subsequently refunded to Scripps Health. Some risk remains that additional adjustments may be made to fiscal 1998, fiscal 1999, or fiscal 2000 cost reports. Accrued liabilities include management's estimated liability related to this issue.

Scripps Health is a party to certain other legal and regulatory actions in the ordinary course of business, including two voluntary self disclosures to the OIG during 2003. While it is not possible to predict or determine the outcome of these actions, it is the opinion of management that there will not be a material adverse effect on the financial position of Scripps Health.

(c) Seismic Standards

Scripps Health has assessed its earthquake retrofit requirements for healthcare facilities under a State of California law that requires compliance with certain seismic standards by 2008. An extension of this seismic compliance deadline to 2013 has been granted for all Scripps Health facilities. Based upon studies performed, the total cost of bringing all facilities into compliance is estimated to be $372 million (unaudited) before inflation.

(15) Retirement Plans

(a) Defined Contribution Savings Plan

Scripps Health provides a defined contribution savings plan for full-time and part-time employees who have completed one year of eligible service. Plan participants contribute 1%, 2%, or 3% of eligible compensation. Scripps Health contributes an amount equal to the employees' contributions up to 3%. Effective January 1, 2004, employees with 10 or more years of service contributing the maximum of 3% will receive a 4%, 5%, or 6% matching contribution, depending on their years of services. The employer contribution vests over three years. For the years ended September 30, 2004 and 2003, Scripps Health recorded plan expense in the amount of $8,286,000 and $5,650,000, respectively.

(b) Nonqualified Supplemental Executive Retirement Plan

Scripps Health maintains a nonqualified supplemental executive retirement plan for certain of its key executives. The plan provides defined benefits to its participants. As of September 30, 2004 and 2003, the plan had eight participants and has been closed to new membership since 2000. The funded status of the plan as of September 30, 2004 and 2003 is as follows:

		2004	2003
		(In thousands)	
Accumulated postretirement benefit obligation	$	4,093	3,393
Plan assets at fair value		4,254	3,938
Plan assets in excess of accumulated postretirement benefit obligation	$	161	545
Accrued postretirement benefit obligation	$	4,466	3,686

For the years ended September 30, 2004 and 2003, Scripps Health recorded plan expense in the amount of $1,869,000 and $1,320,000, respectively.

(Continued)

(c) Executive Benefit Plan

During fiscal 2003, Scripps Health implemented an annual pretax benefit plan for executives that includes long-term care coverage, spouse and supplemental survivor life insurance coverage, supplemental retirement benefit accounts, and various other benefits. Scripps Health provides each participant with an annual flexible benefit allowance, based on a percentage of each participant's annual salary, from which participants may purchase various benefits or invest in a supplemental accumulation retirement account (SARA). The participants vest in the amount invested in the SARA over two years. In addition, Scripps Health advances certain insurance premiums for ten years and retains an interest in the applicable policies equal to the cumulative premiums paid. Scripps Health will then recover its advances at the earliest of termination, retirement, disability, or death. For the years ended September 30, 2004 and 2003, Scripps Health recorded plan expense in the amount of $921,000 and $908,000, respectively.

(16) Gain on Sale of Property

During fiscal 2002, Scripps Health sold its Skilled Nursing facilities for $8,030,000. A portion of the selling price, in the amount of $4,000,000, was in the form of a note receivable and the balance was received in cash. The gain on sale related to the portion of the selling price not received in cash is being recognized on the installment method. Gains are being recognized as principal payments on the note receivable are received. Scripps Health gains on sale of the Skilled Nursing facilities for the years ended September 30, 2004 and 2003 were $27,000 and $13,000, respectively. Deferred gains on the sale amounted to $1,404,000 and $1,446,000 at September 30, 2004 and 2003, respectively.

During fiscal 2004, Scripps Health sold real estate in Encinitas for $725,000 and recorded a gain on sale of $176,000. During fiscal 2003, real estate in Chula Vista was sold and a gain on sale of $695,000 was recorded.

(17) Functional Expenses

Operating expenses are grouped into functional classifications as summarized below. Patient care services include all expenses incurred by departments directly delivering patient care or directly supporting the delivery of patient care. Other general and administrative services include information services, financial services, employee relations services, insurance, and administration and related services.

	2004	2003
	(In thousands)	
Patient care services	$ 1,232,013	1,139,490
General and administrative	69,235	85,989
Fund-raising	10,370	8,662
Total operating expenses	$ 1,311,618	1,234,141

(Continued)

(18) Fair Value of Financial Instruments

Scripps Health estimates the fair value of each class of financial instrument as follows:

Cash, accounts receivable, other current assets, other assets, accounts payable, accrued liabilities, and other liabilities: The carrying amounts approximate fair value.

Investments: The fair values of debt securities and equity investments are based on quoted market prices at the reporting date for those or similar investments.

Long-term debt: The fair value of Scripps Health's long-term debt is estimated based on the quoted market prices for the same or similar issues or on the current rates offered to Scripps Health for debt of the same remaining maturities (see note 8).

Schedule 1

SCRIPPS HEALTH

Supplementary Schedule – Consolidating Statement of Financial Position Information

September 30, 2004

(In thousands)

Assets	Obligated Group	TWI	SCHPS	Eliminations	Consolidated
Current assets:					
Cash and cash equivalents	$ 51,615	296	14,951		66,862
Accounts receivable, net	179,459	152	185	(1,561)	178,235
Other current assets	53,836	394	502		54,732
Total current assets	284,910	842	15,638	(1,561)	299,829
Investments	348,833	5,417	300		354,550
Property, plant, and equipment, net	472,243	789	50		473,082
Other assets	121,718	3,721	—	(1,000)	124,439
Total assets	$ 1,227,704	10,769	15,988	(2,561)	1,251,900
Liabilities and Equity					
Current liabilities:					
Current portion of long-term debt	$ 7,746	—	—		7,746
Accounts payable	60,184	72	30		60,286
Accrued liabilities	149,798	131	12,006	(1,561)	160,374
Total current liabilities	217,728	203	12,036	(1,561)	228,406
Long-term debt	309,648	—	—		309,648
Other liabilities	45,511	—	172		45,683
Total liabilities	572,887	203	12,208	(1,561)	583,737
Equity:					
Unrestricted	531,037	2,096	3,780	(1,000)	535,913
Temporarily restricted	73,463	2,369	—		75,832
Permanently restricted	50,317	6,101	—		56,418
Total equity	654,817	10,566	3,780	(1,000)	668,163
Total liabilities and equity	$ 1,227,704	10,769	15,988	(2,561)	1,251,900

See accompanying independent auditors' report.

Schedule 2

SCRIPPS HEALTH

Supplementary Schedule – Consolidating Statement of Operations Information

Year ended September 30, 2004

(In thousands)

	Obligated Group	TWI	SCHPS	Eliminations	Consolidated
Revenues:					
Healthcare delivery	$ 1,218,617	—	130,055	(84,530)	1,264,142
Other operating revenue	43,554	1,199	6,893	(968)	50,678
Investment income	12,374	117	94		12,585
Contributions	1,146	435	—		1,581
Gain on sale of property	206	—	—		206
Equity released from restrictions used for operations	20,312	3,164	—		23,476
Total revenues	1,296,209	4,915	137,042	(85,498)	1,352,668
Expenses:					
Wages and benefits	580,556	2,298	5,124		587,978
Supplies	255,510	203			255,713
Services	296,826	3,018	131,829	(85,498)	346,175
Provision for uncollectible accounts receivable	58,354	—	—		58,354
Depreciation and amortization	53,118	59	27		53,204
Interest	10,194	—	—		10,194
Total expenses	1,254,558	5,578	136,980	(85,498)	1,311,618
Operating gain (loss)	41,651	(663)	62	—	41,050
Other gains, net	24,920	692	—	—	25,612
Net increase in unrestricted equity	$ 66,571	29	62	—	66,662

See accompanying independent auditors' report.